S. Hrg. 101-1038

HEALTH CARE FRAUD/MEDICARE SECONDARY PAYER PROGRAM

HEARINGS

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 11, 12, 1990

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HEALTH CARE FRAUD/MEDICARE SECONDARY PAYER PROGRAM

WEDNESDAY, JULY 11, 1990

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room SD–342, Dirksen Senate Office Building, Hon. William V. Roth, Jr., presiding.

Present: Senators Roth and Cohen.

Staff present: Eleanore Hill, Chief Counsel/Staff Director; Mary Robertson, Chief Clerk; Cynthia Comstock, Staff Assistant to the Chief Counsel; Kimberly O'Dell, Staff Assistant; R. Mark Webster, Investigator; Daniel Rinzel, Minority Chief Counsel; Stephen Levin, Minority Counsel; Janet Rehnquist, Minority Counsel; Mary K. Vinson, Minority Chief Investigator; Sallie Cribbs, Executive Assistant to the Minority Chief Counsel; Carla Martin, Assistant Chief Clerk to the Minority; Blaine Phillips, Staff Assistant to the Minority; Bonnie Hogue (Senator Pryor); Bobby Franklin (Senator Pryor); Bruce Singleton (Senator Sasser); Heather Colby (Senator Rudman); Pricilla Hanley (Senator Cohen); Norman Lorange (Senator Stevens); Ellice Halpren Barnes (Senator Stevens); and John Nakahata (Senator Lieberman).

[Letter of authority follows:]

Pursuant to Rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the Chairman, or any Member of the Subcommittee as designated by the Chairman, to conduct open and/or executive session hearings without a quorum of two members for the administration of oaths and the taking of testimony in connection with hearings on Health Care Fraud/Medicare Secondary Payer Program to be held on July 11 and 12, 1990.

SAM NUNN,
Chairman.
WILLIAM V. ROTH, Jr.,
Ranking Minority Member.

OPENING STATEMENT OF SENATOR ROTH

Senator ROTH. The Subcommittee will be in order. I regret that our chairman, Sam Nunn, cannot be here this morning because of a markup in Armed Services. But I do appreciate his holding this hearing today which, of course, is a part of a series of hearings held by the Subcommittee on fraudulent practices in the health care industry.

In May, as a result of the very excellent investigative work done by the majority staff, we heard about the serious problems of fraud affecting multiple employer welfare arrangements. Last month we heard about abusive practices by certain so-called revenue recovery firms, some of whom are improperly jacking up hospital bills.

Today's hearing focuses on problems and abuses in one part of the Medicare program, the Medicare Secondary Payer, or what we call the MSP program. This program involves primarily the working elderly; people who are over 65 but who are still employed and have private health insurance through their employer. The Medicare Secondary Payer program is designed, as its name implies, to ensure that the private insurance by which people are covered pays the primary cost of medical bills while Medicare pays secondary.

The MSP program involves a complex legislative scheme that requires several different entities to perform certain functions. Frankly, there is always a danger of everyone's eyes glazing over when faced with the acronyms, the jargon, and the complexity of such programs as MSP. I hope that does not happen here today because the fact is that failure to follow the MSP law is costing the taxpayer billions of dollars. Various government sources estimate that losses to the Federal Government as a result of the MSP program range from $400 million to $1 billion per year. Studies by the General Accounting Office and the Inspector General of the Department of Health and Human Services have repeatedly identified the MSP program as gushing with leaks of Federal tax dollars.

Now why are we confronted with these staggering losses a decade after the first MSP provisions were enacted by Congress? Our investigation has uncovered some answers to this question which I hope will lead to improvements in implementing the MSP program. It is clear that the success of the program relies on each entity involved in the process complying in good faith with its legal obligations. This has not always happened.

For several years we have been relying on the honor system to ensure compliance with the MSP. This must stop. Our investigation shows, I am afraid, that medical care providers such as hospitals, Medicare contractors which administer Medicare benefits, private insurance companies the Health Care Financing Administration, and yes, the Congress each share some responsibility for the failures of the MSP program.

The essential problems of the MSP program can be broken down into the following components. First, the law requires hospitals to collect accurate information from patients regarding possible sources of private insurance they may have other than Medicare. This is not routinely done. Hospitals, whether knowingly or as as result of carelessness, submit claims to Medicare using improper codes in an attempt to expedite payment.

Second, the Medicare contractors are hampered by burdensome regulations from doing a better job of identifying private insurance coverage which should pay claims ahead of Medicare. There are inadequate external incentives to ensure that we are getting the maximum bang for the buck from Medicare.

And finally, some private insurance companies have capitalized on what can be charitably described as gross inefficiencies in the administration of Medicare to evade their legal obligation to pay

claims primary to Medicare. Over the next two days, we will hear from representatives of each of these entities.

We will hear today from one insurance company that allegedly followed a deliberate policy of evading payments on claims of patients they had insured by foisting these claims off on Medicare. I want to make clear that we are not here to judge guilt, innocence or liability or any particular party to these proceedings. That is the job of the courts. But we do intend to fully examine the actions of each entity to determine whether we need to change the law.

While MSP is only a small part of the overall Medicare program, I find the waste of up to $1 billion a year in this one program absolutely astounding. In my view, it gives the lie to claims that the Federal Government needs to raise taxes to make its budgetary ends meet. Until we get our house in order on the waste, fraud, and abuse that cost the taxpayers so dearly, we have no right to ask these same taxpayers to shell out even more in taxes.

I want to publicly express appreciation to the General Accounting Office, the Inspector General of the Department of Health and Human Services for their assistance to the Subcommittee during the course of this investigation. Again, I thank the chairman for his leadership and support in fighting fraud and abuse in the health care area.

Because of the importance of attorney-client privilege, I ask that Exhibit JJ be printed at this point in the record rather than in the appendix with the other exhibits.

[Exhibit JJ follows:]

EXHIBIT JJ

ATTORNEY-CLIENT PRIVILEGE EXHIBIT

In the course of its investigation of the Medicare Secondary Payer ("MSP") program, the Subcommittee has been examining allegations that insurance companies, including Provident Life & Accident Insurance Company, have failed to comply with their legal obligations as established by the so-called "MSP laws" to pay certain claims as the primary payer with Medicare being the secondary payer. This has resulted in sizeable overpayments by Medicare.

As part of this inquiry, the Subcommittee subpoenaed documents from Provident and scheduled depositions of current and former Provident employees. Provident objected that one document subpoenaed by the Subcommittee was subject to the attorney-client privilege. Further, Provident argued that the Subcommittee was bound by a ruling to that effect regarding the document in question, which had been made by the United States District Court for the Eastern District of Tennessee in pending civil litigation in which Provident is a party.

In order to prevent the Provident employee who authored the document at issue from producing or testifying about it to the Subcommittee, Provident petitioned the United States District Court for the Eastern District of Tennessee to enjoin the employee from producing the document. Provident also sought an order preventing this employee from testifying about any of the company's attorney-client privilege matters without the court's permission.

The Subcommittee, through the Senate Legal Counsel and the Minority Chief Counsel, appeared as *amicus curiae* in the June 11, 1990 hearing on Provident's petition in order to oppose the request for injunctive relief against the subpoenaed witness. After considering written memoranda and hearing oral argument, the district court denied Provident's request and issued a memorandum (a copy of which is attached). In that memorandum, issued on June 13, 1990, Judge R. Allan Edgar explained that among the reasons for the court's decision were that Provident failed to allege a case or controversy, that the issue was not ripe for judicial determina-

tion, and that Provident had failed to fulfill the equitable requirements for preliminary injunctive relief. The court also noted that its earlier ruling on the attorney-client privilege "which is not of constitutional dimensions, is certainly not binding on the Congress of the United States."

Following the court's ruling, the Chairman heard testimony and additional arguments in executive session concerning Provident's assertion of the attorney-client privilege regarding the document in question. In the June 7, 1990 executive session, Chairman Nunn initially advised Provident, "The attorney-client privilege is a common law rule of evidence which protects certain confidential communications between a client and a lawyer from compelled disclosure. Congress has in the past often been willing to recognize valid assertions of the privilege—this Subcommittee also. . . . The burden is then, as I see it, on you as the party claiming the privilege to demonstrate that the privilege exists and to tell us why. I will hear from you about whatever you would like to tell us concerning why this is privileged and then I will make a determination on that question."

With regard to Provident's assertion that the Subcommittee was bound by the District Court's ruling on this question, the Chairman noted, "I am aware that a Magistrate of the Eastern District of Tennessee has ruled that the memorandum is privileged. However, the court's order only states that you do not need to provide the memorandum to another party in that litigation. It does not say anything about the validity of a subpoena issued to you or to Marilyn Shelley [the subpoenaed witness] by the Subcommittee. . . . The order you are relying on does not on its face apply to the proceedings of this Subcommittee. The court has made a ruling governing its proceedings and, as the Chairman of the Subcommittee, I will make a ruling governing these proceedings."

In addition to the question of whether the document in question was privileged, the Chairman indicated that this matter involved the question as to whether Provident has waived the privilege by turning this document over to the Department of Justice in connection with another investigation without a clear assertion of the attorney-client privilege. "The memorandum that you claim to be privileged was given to the Government by the company and is now publicly available," said Chairman Nunn. "That poses a question as to whether, even if you had a privilege, it has been waived unless you can show something to this Subcommittee that indicates there was not a waiver. Again, I think the burden is on you to demonstrate that any privilege you do have has not been waived by disclosing the document to the Government."

In the June 15, 1990 executive session, the Chairman ruled that Provident had waived any privilege that may have been attached to the document in question when it provided the document to the Department of Justice. The Chairman noted, "We have been into this in considerable detail, much more than we normally do in these matters, but I take the attorney-client privilege seriously . . . we all take that seriously.

"However, it is my view that the burden of establishing the privilege rests with the parties asserting the privilege, and without getting to the question . . . as to whether the document itself was indeed privileged in part or in total, I think that, in my view, even assuming that parts of it were privileged, then the question arises as to whether the privilege has been waived . . . I cannot find that Provident has met its burden in establishing that the privilege, if it existed, has not been waived. The document is in the possession of the Subcommittee and on the public files in several courts. Under all the circumstances, I find that whatever privilege may once have existed with respect to the document or parts of the document, it no longer exists and has been waived . . .

"It is my ruling that during the deposition of Marilyn Shelley, the March 5, 1985 memorandum written by Marilyn Shelley to Dana Reynolds may be the subject of inquiry by Subcommittee staff conducting the deposition and such inquiries are not subject to exclusion on the basis of the attorney-client privilege." However, the Chairman also directed the Subcommittee staff to remain sensitive to the possible existence of the attorney-client privilege during the course of questioning the employee witness.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
SOUTHERN DIVISION

In the Matter of	)	
	)	
	)	CIV-1-90-219
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY	)	

M E M O R A N D U M

A hearing was held on June 11, 1990, upon the motion of Provident Life and Accident Insurance Company ("Provident") for a preliminary injunction[1] restraining Marilyn D. Shelley, a Provident employee, from producing information or testifying before the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs ("Senate Subcommittee") about matters subject to Provident's asserted attorney-client privilege. (Court File No. 2). For the reasons stated on the record and herein, Provident's motion is DENIED.

In order to be entitled to this extraordinary relief, Provident must satisfy three separate requirements: (1) whether a case or controversy exists, (2) whether that case or controversy is ripe for judicial review, and (3) if ripe, whether Provident is entitled to the injunctive relief sought.

Article III of the Constitution limits the exercise of judicial power to "cases" and "controversies." Before a

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[1] Provident has asked that its motion for a temporary restraining order be treated as one for a preliminary injunction in the event the Court held a hearing thereon. The Court did hold a hearing.

"controversy" is appropriate for judicial determination, it "must be definite and concrete, touching the legal relations of parties having adverse legal interests." Aetna Life Ins. Co. v. Haworth, 300 U.S. 227, 240-41 (1937). See Babbitt v. Utd. Farm Workers Nat'l Union, 442 U.S. 289, 298 (1979); Maryland Cas. Co. v. Pac. Coal & Oil Co., 312 U.S. 270, 273 (1941). Provident has failed to fulfill this most basic requirement. In its petition for injunctive relief (Court File No. 1), Provident has merely styled the case "In the Matter of Provident Life and Accident Insurance Company." In addition to not setting forth the name(s) of any adverse parties in the caption pursuant to Fed. R. Civ. P. 10(a), Provident has failed to establish the existence of any party with an adverse legal interest to that of Provident's. Clearly, Provident cannot obtain an order enjoining the members of the Senate Subcommittee. See Eastland v. United States Servicemen's Fund, 421 U.S. 491 (1975). The only other available person or entity with possible adverse legal interests is Marilyn Shelley. Provident has not established that her interests are adverse to Provident's. Instead, Provident has only alleged that Ms. Shelley "might not assert Provident's attorney-client privilege on behalf of Provident." (Court File No. 2 at 1) (emphasis supplied). On the other hand, Ms. Shelley is equally likely to assert Provident's attorney-client privilege. It is only in the former case that a "case" or "controversy" would exist, and Provident has not shown to this Court that it is the former case that does in fact exist. Compare United States v. American Telephone & Telegraph Co., 567 F.2d 121 (D.C. Cir. 1977).

Even if Provident had set forth sufficiently concrete allegations to establish a case or controversy, Provident still faces certain prudential limits on this Court's exercise of jurisdiction imposed by the ripeness doctrine. The "[r]ipeness doctrine reflects the determination that courts should decide only `a real, substantial controversy,' not a mere hypothetical question." 13A C. Wright, A. Miller and E. Cooper, Federal Practice and Procedure § 3532.2 (1984). See Abbott Laboratories v. Gardner, 387 U.S. 136, 148-49 (1967); Action Alliance of Senior Citizens v. Heckler, 789 F.2d 931, 939-40 (D.C. Cir. 1986). Whether an issue is ripe for determination involves a two-fold inquiry into (1) the fitness of the issue(s) for judicial determination and (2) the hardship to the parties if a decision is withheld by the court. Abbott Laboratories, 387 U.S. at 149. In the present case, several contingencies exist which preclude judicial intervention at the present time. First, the Senate Subcommittee has pending before it the question of Provident's asserted attorney-client privilege. It is entirely possible that the Senate Subcommittee will agree with Provident's assertions and uphold the privilege. Second, even if the Senate Subcommittee does question Ms. Shelley about matters held privileged by this Court, Ms. Shelley may assert that privilege and the Senate Subcommittee may honor her assertion and not pursue the matter further. Further, as will be discussed more thoroughly infra, Provident is not likely to suffer any irreparable harm from this Court's refusal to grant the requested relief. All of these contingencies combine to make this action not ripe for determination.

Lastly, Provident has failed to fulfill the equitable requirements for preliminary injunctive relief. This Court must evaluate (1) whether Provident has shown a strong likelihood of success on the merits; (2) whether the issuance of an injunction would substantially harm others; (3) whether Provident will suffer irreparable harm in the absence of such an order; and (4) whether the public interest would be harmed or served by such an order. Higgs v. Bland, 888 F.2d 443, 448 (6th Cir. 1989) (citation omitted).

Provident fails on all four prongs. First, Provident has not shown that it is likely to succeed on the merits. As previously discussed, Provident suffers from both Article III and ripeness problems. At the present juncture, therefore, this Court cannot find a likelihood of success on the merits. Second, the harm to others could be substantial. If this Court were to issue a preliminary injunction, it could inhibit the legitimate investigatory powers of the Senate Subcommittee; it could also place Ms. Shelley between the proverbial "rock and a hard place," facing possible contempt citations from two different branches of the government. Third, Provident is unlikely to suffer irreparable harm. If privileged matters are disclosed, it is not certain that they will be disclosed to the public. Ashland Oil, Inc. v. F.T.C., 548 F.2d 977, 979 (D.C. Cir. 1976) ("`[T]he courts must presume that the committees of Congress will exercise their powers responsibly and with due regard for the rights of affected parties.'" (citation omitted)). Even if disclosed, such disclosure is unlikely to have any effect upon the litigation pending before

this Court. On the other hand, if Ms. Shelley asserts the privilege, Provident and/or Ms. Shelley may address the matter either through the procedures set forth in 28 U.S.C. § 1365 (Supp. 1990) or in the appeals process available in cases of contempt. Lastly, the public interest would not be served by the issuance of a preliminary injunction. Congress, as represented in this case by the Senate Subcommittee, stands as a separate and co-equal branch of government which is capable of making its own determinations regarding privileges asserted by witnesses before it. This Court's ruling that a portion of the March 5, 1985 Shelley memorandum is subject to the attorney-client privilege was an evidentiary ruling applying only in the case before this Court in which it was made, United States of America ex rel. Stinson, Lyons, Gerlin & Bustamante P.A. v. Provident Life and Accident Insurance Company, CIV-1-89-331. That ruling, which is not of constitutional dimensions, is certainly not binding on the Congress of the United States.

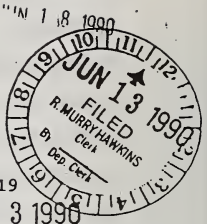
For all of these reasons, Provident's request for a temporary restraining order and for a preliminary injunction will be DENIED.

SO ORDERED.

ENTER.

R. Allan Edgar

R. ALLAN EDGAR
UNITED STATES DISTRICT JUDGE



UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
SOUTHERN DIVISION

In the Matter of)
)
)
PROVIDENT LIFE AND ACCIDENT)
INSURANCE COMPANY)

CIV-1-90-219

Filed JUN 13 1990

Ent'd Order Bk. 45, p. 191

R. MURRY HAWKINS, CLERK

JUDGMENT By _____
Dep. Clerk

For the reasons expressed in the Court's memorandum filed herewith, as well as those expressed on the record at a hearing in this cause held on June 11, 1990, Provident Life and Accident Insurance Company's request for preliminary injunctive relief is DENIED. Since this was the only relief requested in this case by Provident, this case is DISMISSED.

ENTER.

R. Allan Edgar
R. ALLAN EDGAR
UNITED STATES DISTRICT JUDGE

ENTERED AS A JUDGMENT
JUN 13 1990
R. MURRY HAWKINS, CLERK
By _____
Dep. Clerk

Senator ROTH. At this time I would be happy to call on my friend and colleague, Senator Cohen.

OPENING STATEMENT OF SENATOR COHEN

Senator COHEN. Thank you, Mr. Chairman. First, let me express my regrets that I will not be able to stay for the proceedings. The Senate Armed Services Committee is currently in its markup and the Sea Power Projection Subcommittee on which I am the ranking member is currently marking up its section of the bill. So I will have to leave following this opportunity to make a few comments.

Number one, I want to endorse what you have said in its entirety. The fact is, the deficit of the Federal Government is driving everything that we do. It is driving our foreign policy, certainly, as we are looking with some regret that we are unable to fund emerging democracies. We are looking to the Eastern Europeans and saying, we are sorry, we do not have money. We are looking to those in the Caribbean basin, those in Central America saying, we are sorry, we are simply out of funds. Therefore, we are altering our foreign policy because of the deficit.

The same thing is true with respect to our domestic policy. We have had President Bush submit a budget which has recommended something in the neighborhood of $5.3 billion in reductions to the Medicare program, over the objection of many of us who serve in the Senate and the House because we feel that the Medicare program is vital to ensuring adequate medical care for our people.

Senator Roth has just touched upon a very raw nerve. That is, the whole "T" word; the question of taxes which has sent shudders through certainly political circles if not financial circles.

Last week we had a debate on the Senate floor in the waning hours of a particular day in which Senator Helms raised an issue. He held up for all of us to see at least one copy of a report that was put together by Citizens Against Fraud, Waste and Abuse in Federal Programs. Most of us had not seen that particular report, but nonetheless, we were intrigued that the group that had put together that report had come to the conclusion that there was at least $130 billion that is wasted.

We have found over the years that fraud, waste and abuse comes in many forms. We have sat behind this dais up here and pointed our fingers at the Defense Department at $600 toilet seats, or $1,200 coffee makers on aircraft, or $200 or $300 screwdrivers. We have seen a multiplicity of fraudulent or wasteful or abusive activities. So there is no one aspect of Government that bears the full responsibility for that.

But now we can look, and Senator Roth mentioned the revenue recovery firms, some of whom have engaged in skullduggery and have simply looked at ways of increasing profit for themselves while causing some hardship for various hospitals. This is another aspect of it.

I do not know whether the fraud that has been referenced as ranging from $200 million to $1 billion is a result of inefficiency. I assume there is some of that there. Perhaps stupidity on our part. But certainly, at least negligence. We do not have the answers at

this particular point as to which category it falls, inefficiency, stupidity, or negligence, but the purpose of the hearing is to find out.

I agree with Senator Roth in saying, before we start talking about substantial tax increases, we have an obligation to root out the kind of fraudulent or wasteful or abusive activity that we can find, wherever we can find it, whether it be in the Defense Department or in the health care programs, and whether it come from the private sector who are taking advantage of programs which are vital for the health and welfare of our citizens or not.

So I commend you, Mr. Acting Chairman, and Senator Nunn whom I will join in a moment. If at all possible, I will try to get back during the course of the day.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR COHEN

Mr. Chairman, the prospect that up to one billion of our Medicare program dollars are being mismanaged or misspent annually is intolerable, particularly at a time of escalating health care costs when America's elderly have seen their annual Medicare deductible and monthly premiums more than double. Therefore I commend you and Senator Roth for calling these hearings to investigate allegations of fraud and abuse in the Medicare Secondary Payer program.

In 1982, in an attempt to control rising Medicare costs, the Congress enacted legislation authorizing the Medicare Secondary Payer program, which is designed to ensure that Medicare does not pay medical bills that other insurers should rightfully cover. The program involves primarily the working elderly—Medicare-eligible individuals who are over 65, but who are still employed and who are covered by private health insurance through their employers. Under this program, the employer group health plans under which these Medicare-eligible individuals are covered are to be the primary sources of payment for their medical care, with Medicare assuming any remaining secondary costs for which it is responsible. While the Medicare Secondary Payer program involves only 5 percent of Medicare beneficiaries, the potential cost-savings are substantial. Medicare saved approximately $1.4 billion in fiscal year 1987 by paying beneficiaries' medical bills only after other responsible insurers had paid.

While significant cost-savings have been achieved over the last 6 years, it appears that many more millions—or even billions—have been misspent. These overpayments may be the result of fraud. Insurance companies may be deliberately foisting off claims on the Medicare program that they know, by law, they should pay. Alternatively, these overpayments may be the result of simple inefficiency or negligence on the part of the Medicare program. Regardless, these overpayments are costing the American taxpayer as much as $1 billion a year and should not be tolerated. We are here today to investigate these charges of fraud and abuse and to review the administration of the entire Medicare Secondary Payer program. It is our hope that we will find ways to rectify these problems, ultimately strengthening the Medicare program which is so critical to the health and welfare of millions of elderly and disabled Americans.

Once again, I commend the chairman and ranking minority member for calling these hearings, and I look forward to the upcoming testimony.

Senator ROTH. I thank the senator. I know of his intense interest in this area and appreciate his help and support.

Senator Pryor was unable to be with us today but he has a statement for the record.

[The statement referred to follows:]

OPENING STATEMENT OF SENATOR PRYOR

Good morning. Mr. Chairman and Senator Roth, I commend you for holding this very important hearing. I am pleased we are focusing much needed attention on the problems in the Medicare Secondary Payer program.

As its name connotes, the Medicare Secondary Payer (MSP) program provides that Medicare is the secondary payer for beneficiaries who have private employer-

sponsored insurance and other forms of liability insurance. In other words, their private insurance is required by law to be the payer of first resort.

What the Subcommittee has found, however, is that it appears many private health insurers—in an attempt to fraudulently maximize profits—have developed schemes to illegally forward claims to the Medicare program that the private insurers are, by law, responsible for paying. In addition, because Medicare contracts out with private insurers to administrator Medicare claims, the private insurers have an inherent conflict of interest in deciding whether Medicare or their company should be paying individual claims. This seems to be a classic case of the fox guarding the chicken coop.

Beyond the insurance industry, there is plenty of blame to spread around. Despite warnings about this problem in a 1988 General Accounting Office report, the Health Care Financing Administration (HCFA) has been slow to address this intolerable situation. Finally, health care providers seem to be contributing to this problem by failing to obtain needed information necessary to correctly file claims.

At a time when we are faced with a huge federal deficit, serious questions about the future solvency of the Medicare program, and continuing and enlarging gaps in access to needed health care, it is shocking to learn that as much as $1 billion of the taxpayers' money is being wasted as a result of problems with the MSP program. This hearing and the Subcommittee's investigation into the MSP program is the first step toward addressing this shameful waste.

This morning we will hear from those who play a key role in the MSP process: private insurance companies, medical care providers, Medicare contractors and HCFA. My hope is that this testimony will help us get to the bottom of this mess and identify what changes need to be made to halt further abuses in the program.

As we unravel what has led to so much wasteful spending of Medicare dollars, we must not overlook the impact the MSP program also has had on Medicare beneficiaries. The Special Committee on Aging, which I chair, has received numerous reports of instances where the implementation of the MSP program has had harsh and unjust consequences on older Americans. In addition to paying for services that are the legal responsibility of private insurers, Medicare has denied payment for services that should have been covered by the program. In addressing the shortcomings in the MSP program, we must work to ensure needed protections for beneficiaries.

The issue we are looking at today is part of a larger problem of health care fraud and abuse. A conservative estimate sets the cost of fraud and abuse within our health care system at $60 billion each year. When Medicare beneficiaries are straining to pay rising premiums, when many of these same individuals are impoverished by long-term care costs, and when Americans of all ages cannot afford health care, this problem must be halted.

As Chairman of the Senate Aging Committee, I plan to focus on other aspects of health care fraud and abuse in the upcoming months. I also hope to work with the Subcommittee in correcting the problems we are focusing on today.

Clearly, the Congress, and this Subcommittee in particular, will not be satisfied until problems with the MSP program are corrected. I am pleased to join the Chairman and the Ranking Minority Member in that very important effort.

Senator ROTH. I would say to all the witnesses appearing today, so that you are aware of the rules by which we will play, that first of all, we have each of your statements. I have read them, and I expect that each of the witnesses will abbreviate them as briefly as possible so that we can proceed with the questions.

Secondly, it is a rule of the Subcommittee, of course, that every witness who testifies has to be sworn in.

So with those rules, I am very happy to welcome as our first witness, Michael Mangano, Deputy Inspector General of the Department of Health and Human Services. Mr. Mangano's office has been very active in uncovering some of the abusive practices in the Medicare Secondary Payer program that, as I said, cost the Government billions of dollars over several years.

We are also very pleased to welcome with him Bob Simon, the Assistant Inspector General for Criminal Investigations, and Larry

Simmons, Assistant Inspector General for Health Care Financing Audits.

[Witnesses sworn.]

Senator ROTH. Mr. Mangano, would you please proceed?

TESTIMONY OF MICHAEL F. MANGANO, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES,[1] ACCOMPANIED BY BOB SIMON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS, AND LARRY SIMMONS, ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE FINANCING AUDITS

Mr. MANGANO. Thank you very much, Senator. We are pleased to be with you this morning to discuss the Medicare Secondary Payer provisions. I would like to begin by briefly describing a history of the MSP program.

The Congress created the Medicare program in 1965 basically to pay for the health care services for eligible beneficiaries age 65 and older. For the first 15 years of the program Medicare was the primary payer, or first payer for all health care claims except when the claimant was covered by workers' compensation, black lung, or veterans benefits. Between 1980 and 1986, the Congress passed a series of statutory provisions which established Medicare as the secondary payer to other insurers in certain circumstances. They included coverage under the automobile, no-fault or liability insurance plan; employer group health plan coverage for beneficiaries who have kidney failure during the first year of Medicare entitlement; coverage under an employer group health plan of working beneficiaries age 65 or older or their spouses; and coverage under an employer group health plan provided by an employer of 100 or more persons for beneficiaries who are disabled.

Under the current procedures, providers are required to ask Medicare beneficiaries a series of questions concerning their health care insurance coverage. Providers are then required to bill other insurers first when the beneficiaries fall within one of the MSP categories described earlier. The Medicare contractors are required to screen all claims for coverage by another insurer.

Numerous studies conducted by the OIG, GAO and HCFA have shown that Medicare continues to be billed as primary payer. In the OIG alone we have conducted 26 separate evaluations and audits concerning MSP since March 1984. I have included them in this black binder which we have made available to you.[2]

The HCFA has also taken a number of actions to improve methods for identifying cases where primary payment sources exist. However, we estimate, conservatively, between $400 and $600 million per year was lost to Medicare in inappropriate payments in 1988, and recent information suggests that the current program losses may be even higher.

I would like to briefly touch on a few of the more recent studies that we have had in this area. In 1988, the OIG published a series of reports covering end-stage renal disease, automobile accidents and related claims, and Medicare beneficiaries covered by employer

[1] See p. 113 for Mr. Mangano's prepared statement.

[2] The information referred to was marked Exhibit UU and retained in the Subcommittee files.

group health plans, which documented a total of $263 million in projected losses to Medicare.

In March 1990, the OIG issued another report entitled, "More Complete Employer Group Health Plan Information Is Needed To Administer the Medicare Secondary Payer Program." This report identified a material internal control weakness in the MSP program which was included in the Secretary's 1989 Financial Integrity Act report to the President and the Congress.

Two weeks ago we issued a management advisory report entitled, "Medicare Secondary Payer: Unrecovered Funds." In this study we analyzed responses received from a national random sample of over 3,000 Medicare beneficiaries. We found in that study between $400 and $600 million in inappropriate Medicare payments were made in 1988.

As you know, the OIG is responsible for investigating *qui tam* lawsuits which involve allegations of fraud pertaining to departmental programs. Any person having knowledge of a false claim against the Government may bring an action in a federal district court for themselves on behalf of the Government. The OIG has thus far conducted five MSP investigations related to suits filed under the *qui tam* False Claims Act. In each case we recommended that the Government not join the *qui tam* suit, but instead reserve the right to intervene at a later time if appropriate.

Our problems in pursuing criminal cases for violating the MSP provisions can be illustrated by a recent experience in investigating the Provident Life and Accident Insurance Company in March of 1988. It was alleged in the lawsuit by a private law firm under the *qui tam* provisions that the insurer had defrauded the Medicare program by intentionally paying benefits as secondary to Medicare when the insurer was aware that they had primary responsibility in numerous cases.

We issued a subpoena for their files concerning payment information for about 250 randomly selected beneficiaries. Unfortunately, the insurer failed to provide all the requested records. After almost 2 years of work we have recently been notified that the Department of Justice has declined to prosecute with the assistant United States attorney declining in favor of a civil recovery action against this insurer for inappropriate payments made by the Medicare program.

We are currently auditing five Medicare contractors to determine if they are complying with the MSP provisions and procedures, and to determine the amount of improper Medicare primary payments.

We have also conducted a computer match of HCFA and Social Security Administration records to determine the total amount of Medicare payments that should have been the primary liability of the insurer. We identified from Social Security earnings records and from HCFA's files that about 8 million Medicare beneficiaries who worked for 1.1 million employers had earnings that could have been covered by employer group health plans.

The Omnibus Budget Reconciliation Act of 1989 mandates the transfer of MSP information between the Internal Revenue Service, Social Security Administration and HCFA. We are using our

match to help HCFA in its implementation of that OBRA 1989 requirements.

Although implementation of the OBRA provisions will help identify and prevent MSP overpayments, we believe that additional actions are necessary. The following OIG recommendations we have made to HCFA would also help correct the MSP problems.

With regard to new legislative initiatives, we recommended that HCFA require employer group health plans to notify HCFA about covered individuals who are over age 65 and enrolled in insurance programs to which Medicare is secondary payer.

Alternatively, this could be absorbed into a broader proposal to establish a national clearinghouse of information pertaining to medical insurance available to beneficiaries of all Federal and State programs. HCFA would basically run its claims information through this clearinghouse in order to identify all MSP situations.

Action could be taken to collect more accurate information to identify primary payers by including modifications to the W–2 forms to collect employer group health information.

The Department should seek legislation to establish a voluntary disclosure and recovery program. The program would basically permit insurers, employers or third-party administrators to identify instances of improper MSP payments and make restitution of the amounts without the threat of future Government action. The legislation would also provide for a waiver of the existing statute of limitations concerning those improper MSP payments.

The Department could seek legislation to require Medicare contractors to match their health insurance with the data files of private insurers.

We have also recommended that HCFA take administrative action to revise all Medicare claims forms to require an answer of yes or no to the question, Do you have health insurance as a result of your or your spouse's current employment?; amend instructions to Medicare contractors to specify that if the section on a claims form pertaining to the employee insurance is blank, the claim should be suspended or returned explaining that the other health insurance coverage question must be answered; develop the first claim filed by a beneficiary each year for potential other primary sources of health insurance coverage; and finally, continue to pursue the fiscal year 1991 budget request in an attempt to increase the resources available to contractors for MSP activities.

The implementation of the MSP provisions has not met the goals intended by Congress. Hundreds of millions of dollars are still being lost each year because the MSP situations cannot be adequately identified and pursued. Actions by HCFA, while achieving savings of $1.4 billion in 1988, have not eliminated the problems.

In this testimony we have outlined numerous actions which could result in substantial recoveries and ensure that the MSP provisions are achieving the goals intended by Congress.

This concludes my testimony. We would be happy to answer any questions you may have.

Senator Roth. Thank you, Mr. Mangano. Let me ask you this question. It is obvious from your last statement that you consider there still to be a serious problem with fraud and abuse today in

the MSP program. What do you believe to be the most serious problems in this program?

Mr. MANGANO. I think it is a combination of factors. We have to look at the whole system. First of all, beneficiaries have an obligation to tell the providers of health care when they enter a hospital or go into a physician's office that they do have other insurance. The providers themselves are required to aggressively ask information of the beneficiaries about other kinds of insurance they have, and then to bill the primary insurer first.

The contractors that Medicare employs have an obligation to aggressively go after the MSP figures. We have another problem, I think that is going to be cropping up in the next couple of years. It is the decline in the amount of money that is available to the carriers to actively carry out some of those MSP investigations. We have seen the money provided for this activity drop over the last year.

Senator ROTH. I hear what you are saying, but here it has been 8 years since the enactment of TEFRA in 1982. But anyway, it concerns me that here in 1990 we say, well, the beneficiaries ought to be correctly giving the information; that the hospitals ought to be securing adequate information as to the coverage. The intermediaries, those that administer the contracts, I think you have said, or your office has said, have a conflict of interest. What about the insurance carriers?

Mr. MANGANO. Absolutely, the insurance carriers themselves are very important to this problem. The insurance companies themselves need to take aggressive actions to ensure that they cover the liability that they are insuring their beneficiaries for. It is very clear in the activities that have been taken about the Medicare Secondary Payer provisions that insurance companies know they have primary responsibility in the instances that are outlined in these laws.

Those insurance companies need to make sure that they, one, pay bills as primary when they are delivered up by the providers. But also, we believe they have a responsibility to aggressively determine when they are primary provider when the Medicare program believes that they are secondary in that case. We would like to see aggressive actions on insurance companies in that regard.

Senator ROTH. What is the general practice of the insurance industry in this regard? Is it a mixed bag? Are some complying in good faith, others not? How would you characterize the industry?

Mr. MANGANO. I would say that the industry when they are delivered a bill as as primary payer, in general, they are paying those bills. Where we are finding the largest portion of unpaid bills as primary insurers comes in those areas where they are not identifying their own beneficiaries, particularly in the working spouse category. The individual insurers know better than anyone else who they are insuring and what their policies cover. They need to be more aggressive in looking at their own private files to see where those situations are that they need to pay primary and do that.

Senator ROTH. What insurance companies or other entities have come to your attention in the course of your work in the MSP area?

Mr. MANGANO. We have five contractors that we are now carrying out audits on. I am going to turn to Larry Simmons to describe the work that is going on in the audit activity right now.

Mr. SIMMONS. Mr. Roth, we are doing work at Empire Blue Cross/Blue Shield that was initiated at HCFA's request. We are also doing audits at Travelers Insurance Company, at Aetna Insurance Company, and at Michigan Blue Cross/Blue Shield. Further, at HCFA's request, we are auditing Florida Blue Cross/Blue Shield.

The purpose of all five of those audits is to determine whether those contractors have made Medicare primary payments when the private insurance side of the business should have had the primary liability. We are trying to determine whether overpayments have occurred under Medicare. If so, we plan to estimate how much those overpayments are and try to seek recovery. They have been difficult audits because we have been resisted at all five contractors.

Senator ROTH. What conclusions, if any, have you reached about the state of compliance with MSP laws by the insurance industry?

Mr. SIMMONS. We have not gotten far enough into the audits, despite being on-site for 1 year to almost 2 years, to determine that. We are farther along at Empire Blue Cross/Blue Shield in the audit than at the other four carriers. We estimate that we are at least a year away from having a final overpayment number, so it is too early to draw conclusions.

The process that we are going through on the audit is kind of tedious. What we have to do is get private business information on the employer group health plans, identify the Medicare beneficiaries that may be insured under those private employer group plans, computer match the eligibility listings under the private group plans to Medicare payment records and then sample those so-called hits to determine whether the Medicare beneficiaries were actually insured by private health insurance for the same period that Medicare made a primary payment.

At Empire Blue Cross we are farther along, as I indicated, and we have identified about 14 million potential claims that may be potential overpayment cases that have to be sampled. That is why it is going to take us about a year to get through the sampling of that voluminous number of claims.

Mr. MANGANO. If I could add to that, I would also make two other points. We are convinced that the private insurance companies have been slow to take aggressive action to identify those situations where they are primary payers. The contractors have also been reluctant to match their private files against the Medicare files—their private insurance files—as a rule. So those are two disappointing features.

Senator ROTH. It concerns me to have you sit here in front of me and say it is going to take another year to come to any conclusions. In the meantime, according to your own figures you have got several hundred million dollars being wasted. Why does it require, as an accounting matter, such detail and such extended studies? I mean, can you not determine by some kind of a spot check as to whether or not they are paying as a primary carrier or not?

Mr. SIMMONS. We have basically two problems. One is collecting the overpayments that may have occurred back to 1983 which is the beginning of the EGHP requirements for working beneficiaries.

Senator ROTH. What about the practices now?

Mr. SIMMONS. That is the second problem, making the system improvements to identify those Medicare beneficiaries that have other insurance to prevent future payments. The OBRA 1989 provision, which requires the match between Social Security, Internal Revenue Service data and HCFA will go a long way toward that, but that is a very cumbersome administrative process.

The end result of all that activity, which HCFA is working on at the moment involves SSA sending their Medicare files to IRS for computer matching against beneficiaries tax returns to identify spouses and link spouses and primary insurers. That information is passed back to HCFA so that HCFA can then notify the employers to determine whether the beneficiaries worked and whether they had coverage by employer group plans. This is a very cumbersome, long process. The answer to who is insured will not come quickly. That is also why it is going to take a number of years to bring the problem under correction.

So we have a problem with past overpayments for potential noncompliance with the rules and the system still is not fixed to prevent future overpayments.

Senator ROTH. But is it not possible to determine what degree of compliance is currently in place without waiting several years? This cannot be business as usual.

Mr. SIMMONS. This whole process is not business as usual. Our relations with the contractors are not business as usual.

Senator ROTH. But you are telling me, Mr. Simmons, that it is going to take another year to come to any final conclusions.

Mr. SIMMONS. Unfortunately, that is the case, yes, sir. And that 1 year may be an optimistic estimate, because as I indicated we are dealing with—and this is not a complete match but a partial match at Empire Blue Cross—has identified 14 million potential claims hits. That 14 million has to be broken down into employer group plan, beneficiary and aggregated for sampling to determine whether those beneficiaries——

Senator ROTH. Let me say this and then I want to proceed with the questions. I can understand that it takes a long time to go back and review in detail the practices of each of these companies from an auditing standpoint. But my concern from the standpoint of Government efficiency is for us to have some kind of an idea of what types of practices among the insurance carriers are causing the government to lose several hundred million dollars per year. I do not want to just single out the insurance carriers. I think the same is true with hospitals.

What are their current practices? Are they recognizing their responsibility as a primary carrier or not? And it does not seem to me that that should be an extended investigation that takes years to complete. Otherwise, I do not think you are ever going to correct the situation.

Mr. SIMMONS. The problem, Senator Roth, is this. The carriers and intermediaries, if they comply with HCFA's 1989 regulations, will certainly improve the process. But the problem is getting a

handle on who all those beneficiaries are that have other insurance. That is why this elaborate process, which was mandated by OBRA 1989, has to be done to identify those individuals.

Senator ROTH. All I am saying is that it seems to me there ought to be some way of spot checking to ensure that the policies mandated by Congress are being followed—that is what I am talking about—not the detail practices. What are the policies of each of these carriers?

Now for example, it is my understanding that your office initiated a criminal investigation of Provident Insurance Company in March 1988. In the course of the investigation you subpoenaed documents from Provident that were never produced. But there was no hearing to enforce compliance with the subpoena. Why was that?

Mr. SIMON. It was an extensive criminal investigation, Senator. We interviewed numerous Provident employees, other witnesses, reviewed many, many documents. But it was a criminal investigation and it was under the ambit of the U.S. Attorney's Office. As a remedy to non-compliance with the IG subpoena, we sought the avenue of grand jury subpoena. So we did not have to come to the Congress or to the courts to enforce our own. As to compliance with the grand jury subpoena, it would really be improper for me to discuss that.

Senator ROTH. Let me ask you this. During the 2-year investigation conducted by your office, what evidence of wrongdoing by Provident did you uncover?

Mr. SIMON. We did find that Provident had profound knowledge of what their liabilities and what the requirements of TEFRA were, but that there was just an institutional unwillingness to pay until someone, Medicare or HCFA, told them how much and when to make payments.

Senator ROTH. Was there any information in particular that led you to recommend that the Justice Department pursue criminal charges against Provident?

Mr. SIMON. In the end we concluded, and the Justice Department concluded, that Provident's conduct did not raise to a level that would sustain a criminal prosecution, particularly with regard to the fact that there were other remedies available. A civil suit had been filed by the Government, and there are ways to determine overpayment through audit and we are pursuing those.

Senator ROTH. Now based on your investigation, what is your opinion of the way in which Provident conducted its business with respect to MSP compliance?

Mr. SIMON. As I said, Senator, it is clear from documents that we received from Provident that they knew their liability, they knew that they should be paying as primary. But there is no question, again from the documents, that they would not pay until someone told them to, and when and how much.

Senator ROTH. Are you saying that in these documents, internal documents that they admitted responsibility or liability as primary carriers?

Mr. SIMON. There is no question.

Senator ROTH. There is no question about that. Now we have some internal memoranda of the Provident Insurance Company

which I would like to show you and ask if you could explain your view of the significance of these documents. Now in January 1983 Provident issued a group claim bulletin instructing employees to, "determine what the Medicare administrator is doing before making payment on this type of claim" because Medicare was not yet set up to handle secondary payments.

The law making Medicare the secondary payer for the working elderly, that is those beyond 65, had just gone into effect on January 1st, 1983. What effect would this memorandum have on compliance with the new law?

Mr. SIMON. It clearly, to me, shows that Provident knew what their obligation was. However, in there it is implicit that if Medicare continues paying as primary they will continue paying as secondary, not as primary. However, they say that they are ready to maintain a log of claims for ready reference so they will pay as primary in the future if called upon to do so.

Senator ROTH. If called upon to do so. Is that written into the law?

Mr. SIMON. I have not read that in the law.

Senator ROTH. Now, effective January 1, 1983, Provident adopted a policy of charging its customers a surcharge of $55 to $75 per month per person over 65 and per covered spouse because of its new liabilities for MSP claims under the then-new MSP law. What does that indicate to you about Provident's understanding of its obligations under the new law?

Mr. SIMON. It is clear to me that they knew that they had payment liability. That they were adjusting their rates accordingly. And again, when called upon, they would pay.

Senator ROTH. In a letter dated September 8th, 1983 from Donald Reardon, associate regional manager for Provident in New York, he wrote the following, "It's quite obvious to everyone that Medicare has no way of knowing who in their claim files is an active employee working for an employer of 15 or more employees. Consequently, they will never be able to track this down and pass it back to the insurance industry."

What is the thrust of that?

Mr. SIMON. In a prior paragraph you will see that the writer is saying that some of their customers have complained about the surcharge that they have been paying. That Medicare is not collecting amounts. This fellow goes on to make a suggestion that because it is quite obvious to everyone that Medicare has no way of knowing how much we will ever be owed, why do we not go ahead and refund the surcharges to our customers.

Senator ROTH. In other words, are you not saying that Provident knew that they had a liability under the law?

Mr. SIMON. The way I read this document, Senator, yes.

Senator ROTH. Now you started out, if I understand you, Mr. Simon, that Provident did understand its legal obligation under the law. That it had a responsibility to pay as primary carrier; is that correct?

Mr. SIMON. That is explicit in all of these documents, Senator, yes.

Senator ROTH. When you say all the documents, you mean Provident documents?

Mr. SIMON. Provident's documents, yes, sir.

Senator ROTH. At the same time, they said they would not pay unless they were requested to do so. Is that correct?

Mr. SIMON. Yes.

Senator ROTH. Was that a requirement under the law?

Mr. MANGANO. The law states that Medicare will be the secondary payer in these situations. It would be incredulous to me to believe that an insurance company would not then determine that they had primary responsibility when they——

Senator ROTH. That was the intent of Congress, was it not, to shift primary liability from Medicare to the private insurance carrier?

Mr. MANGANO. That is correct. And HCFA did do a number of things to get that information out, like writing to all the state insurance commissioners. They have since written to providers and the like. So it would be almost impossible for me to believe that an insurance company did not know they would have liability.

Senator ROTH. Is that not the significance of their surcharge? What was the purpose of the surcharge?

Mr. SIMON. The purpose of it was to increase their revenues to offset the possible expenditures, additional expenditures they would have under their primary payment obligation.

Senator ROTH. If I understand you, what you are saying, the purpose of the surcharge was to pay for the increased liability that had resulted as a result of the change of the law; is that correct?

Mr. SIMON. Yes, Senator.

Senator ROTH. Now Marilyn Shelley, a training and communication analyst for Provident wrote in a memorandum in March 1985 to her supervisor that, in her opinion, Provident claims instructions created a violation of law. Mrs. Shelley testified in a deposition before the Subcommittee staff that no one in the company ever responded either verbally or in writing to her concern.

Based on your investigation, can you draw any inferences or conclusions from this document written by an employee whose job it was to analyze and report on claims processing? And can you comment on the lack of a response by the company despite a follow-up memorandum?

Mr. SIMON. I think it underscores our impression that Provident was determined to not pay until someone told them when and how much they were to pay.

Senator ROTH. Now we have several different numbers concerning how much money, waste, fraud and abuse in the MSP program has cost the Government over the years. There are estimates of losses ranging from $700 million to $1 billion per year. What are your best estimates of the amount of money lost per year on the MSP program?

Mr. MANGANO. We think that the amount changes each year. The last study that we have done on data from 1988 indicates a range of between $400 and $600 million. Let me tell you for just a minute or two about how we did the study so you will understand why that is a very conservative figure.

In doing that study, we took a 1 percent sample of Medicare beneficiary claims. We wrote to the beneficiaries and asked them, do you have other insurance coverage? Did you have an accident

during the year which another insurer paid? Everyone that responded, which was 75 percent, we followed up with. Everyone that responded positively we followed up with and then came to that estimate of $400 to $600 million.

What we cannot account for are the 25 percent who did not respond, or the people who may have lied or forgot that they had other insurance coverage when they answered the response. So we believe that the $400 to $600 million is a conservative figure. We believe that that figure is going to be going up over the next couple of years because of the reduction in the MSP money available to contractors to actually carry out these investigations.

Senator ROTH. Now your office has been active in suggesting solutions and corrective measures to the MSP program. As you see the problems now, what solutions do you think would be the most effective in correcting the existing problems?

Mr. MANGANO. We think a number of things would be helpful.

Senator ROTH. Can you say them simply so everybody can understand them, please?

Mr. MANGANO. Yes. One is to have the insurers and contractors on their private side make their beneficiary information available to Medicare so that Medicare can match files against that.

Second, we believe that the contractors ought to develop the first claim each year, so that when an individual goes into the hospital or goes to see their doctor, that Medicare actively follow up on that claim to ensure that there is not another primary insurer involved in that.

We think those two approaches would really go a long way to resolving the problem at the front end, which is the most important part, rather than having to track back years later to find out what the problems were.

Senator ROTH. Now let me ask you this question. What can be done about the hospitals? As I understand it, the information that they provide in many cases is very inaccurate. They are responsible for obtaining information from patients as to what health coverage that individual has; is that correct?

Mr. MANGANO. That is absolutely correct.

Senator ROTH. And yet this has failed. We have seen and will show later that there are hospitals that as a matter of course just put down inaccurate information. Now what can be done about that? This is 10 years after the first MSP laws were enacted? It seems to be in some cases an established practice for hospitals to submit inaccurate information to intermediaries. Is this requirement too cumbersome for hospitals? Who asks for the information? Are they minimum paid and so forth?

Mr. MANGANO. This is information that is requested when a patient is checked into a hospital on the admissions form itself. Every one of us that has been to a hospital knows that we sit down there at the admissions desk, either ourselves or a spouse or a friend, and we will fill out that information. It asks some very simple information. Do you have other kinds of health insurance coverage?

Now if the information is incorrect one of two things are happening. Either the person coming into the hospital is not disclosing that information to the hospital, or the hospital is not being diligent in asking for that information or recording it inappropriately.

When that happens, we have made a recommendation. When claim forms come into the contractors, if the question that deals with other insurers is blank, do not pay it. Send it back and get the information before we do pay it as primary.

Senator ROTH. Now you have indicated that you have recommended that all Medicare claim forms require a very simple answer of "yes" or "no" to the question, "Do you have health insurance as a result of your or your spouse's current employment?" Having read the prepared statement of Mr. Walker of Provident, he raises this same issue. Why has that recommendation not been followed? It does not sound, at least on the surface, very complex, but yet it is not being done. How many years do we have to wait?

Mr. MANGANO. We have made that recommendation to the Health Care Financing Administration and our understanding is that they are moving now to change the forms to do that.

Senator ROTH. What do you mean, moving now? It is July of 1990.

Mr. MANGANO. We have made that recommendation. Our role is to make that recommendation. It is HCFA's responsibility to——

Senator ROTH. I understand that that is all you can do.

Mr. SIMMONS. We made the recommendation in March of 1989—March of 1990, I beg your pardon—and HCFA's response was that the billing form is not 100 percent under their jurisdiction and they would look into it. They considered it a pretty good recommendation, but OBRA 1989 initiated some other things and HCFA agreed to take it all under consideration and just determine what to do from that point on.

Senator ROTH. In its prepared statement to the Subcommittee, Provident criticized the Government for failure to seek the insurance industry's assistance on MSP matters, and for not issuing any written instructions to the insurance industry about what to do about mistaken payments by Medicare. What do you say about these complaints?

Mr. MANGANO. I can look at it in two ways. One, should HCFA issue specific instructions? I think they probably should.

On the other hand, I think the law is clear that people should be paying this—paying as primary responsibility where the situation meets it. So HCFA certainly has had numbers of discussions and communications with the state health insurance commissioners, and with providers, and a variety of people to make known to them a responsibility to pay these obligations.

So it is a question of—if people know that they are responsible, do they want the Government to come in and lay out step by step, here is what thou shalt do. One of the complaints we hear most often is the Government is too prescriptive. If we tell people what the law is, they can create internal procedures to ensure that that occurs.

Senator ROTH. I strongly agree with you on that point. It seems to me that a good faith effort does not depend on detailed regulations. As a matter of fact, one of the main complaints we get concerns regulating the private sector by the Government. I have supported trying to deregulate private business in many cases. I do not want to attack those in the insurance industry that are complying with MSP in good faith. We recognize and appreciate that.

But the fact is, the insurance industry cannot have it both ways. You cannot complain about the over-regulation and then say, well, we did not do anything because there was not a precise regulation on this matter. Was there any doubt in anybody's mind as to why Congress passed this series of laws shifting primary liability away from Medicare and to the private sector.

Mr. MANGANO. I do not know of any doubt.

Senator ROTH. Gentlemen, time is passing on. I do want to stress again that I do not think this is a situation where we can afford to delay and wait for the final detailed answer on the audits performed by your office. We ought to know what the basic industry practice is. Then I think it is your responsibility to make sure that both the Congress—I think Congress shares a lot of the responsibility, as well as the Executive branch, to ensure that those recommendations are carried out.

I appreciate your being here, and we may have some additional questions to ask you.

Mr. MANGANO. Thank you.

Senator ROTH. Our next two witnesses will be Luis C. Bustamante, who is an attorney in private practice from Miami, Florida. Mr. Bustamante is accompanied today by his associate, Tracy Tomlin, who is also a lawyer with the firm. Mr. Bustamante has played a key role in bringing some of the failures of the Medicare Secondary Payer program to the attention of the Federal Government. He is also a plaintiff in a private lawsuit against Provident and some other insurance companies.

I want to re-emphasize that we are not here to try these lawsuits or decide who is guilty or not guilty of violation of the law. But we are interested in the facts so we can decide what needs to be done in terms of changing the laws or possibly the regulations.

[Witnesses sworn.]

Senator ROTH. Mr. Bustamante, as I mentioned, please summarize your testimony and your full statement, of course, will be included.

TESTIMONY OF LUIS C. BUSTAMANTE, ESQ., STINSON, LYONS, GERLIN & BUSTAMANTE, P.A.,[1] ACCOMPANIED BY TRACY E. TOMLIN, ESQ.

Mr. BUSTAMANTE. Thank you, Senator Roth, Ms. Hill, Mr. Rinzel. Myself and Mr. Tomlin welcome the opportunity to respond to the Subcommittee's request for us to appear here this morning to answer questions on this particular problem which is a major problem.

The fraudulent and abusive practices of the insurance companies that are being addressed this morning in part came to my attention in the early 1980's as I represented a client who was involved in a severe automobile accident. My client at the time of the accident was 65 years old, eligible and entitled to Medicare. He was also employed at the time through his own company and eligible for group health benefits under a policy of insurance issued by Provident Life and Accident Insurance Company. My client's inju-

[1] See p. 138 for Mr. Bustamante's prepared statement.

ries rendered him a quadriplegic. His medical expenses and nursing expenses exceeded $1 million.

As a result of the litigation that arose because of that automobile accident, my law firm, myself and Mr. Tomlin came across numerous documents from the Provident Life and Accident Insurance Company regarding the Medicare Secondary Payer program and the practices and procedures implemented by Provident. Indeed, the information that was independently gathered through our own investigation as well as discovery established and indicated to me that Provident was intentionally instructing its employees not to follow the law.

All of this information that was gained by our office through our investigation was submitted to the Government as early as December of 1984 and continuing on through to today. As members of the Committee know, the MSP laws were intended to effect one single purpose. That is to shift the burden from the Federal Government to the private sector for the payment of the medical bills of the working aged.

During my investigation and discovery I found numerous examples of abusive practices by Provident. First, and I think it is of utmost importance to realize that throughout all the documents, all the information that was gathered, that Provident at all times knew that they were obligated to pay and process for payment the medical claims of the working aged on a primary basis. There is no doubt and there is no dispute over that. The records clearly establish that.

Despite this particular knowledge, Provident decided to instruct its employees to process the claims in violation of law. They indicated that they should withhold payment on these bills that would come in until such time as Medicare paid them and then they would pick up the balance.

The memoranda clearly indicate that Provident was well aware of the procedures that were in place by Medicare and how they could take advantage of these procedures. Provident received confirmation from field offices that Medicare had not adequately set up—the system was not set up to handle this particular law and the effect that it had on the handling of these bills.

Second of all, they knew that Medicare had no way of knowing what beneficiaries were covered. The necessary information is specifically located within the files of the employers and the insurance companies that handle those group health plans.

Lastly, they knew that there would be no way to track it down and pass it back to the insurance industry as Mr. Reardon's memorandum pointed out.

As purported justification for ducking their primary liability on these claims, Provident also issued in January of 1983 instructions requiring its employees to maintain a log of payments which Provident should have paid as primary but instead paid as secondary. The logs, in effect, would reflect the amount of money that was owed by Provident to the Government.

According to a memorandum prepared by Marilyn Shelley on March 5, 1985, the practice of maintaining logs was still in effect at that time.

Senator Roth. What year was that?

Mr. BUSTAMANTE. This was March 5, 1985.

Senator ROTH. So they initially started the requirement for logs when?

Mr. BUSTAMANTE. January 14, 1983.

Senator ROTH. So two years later, at least one responsible employee was of the opinion that logs were still being maintained?

Mr. BUSTAMANTE. Yes, sir. This memorandum also clearly points out that as far as Ms. Shelley's viewpoint is concerned, and she was a supervisor for a claims unit, that Provident's claims procedures created a violation of Federal law. These logs have apparently been discarded or destroyed because Provident asserts today and asserted back in the summer of 1986 that the logs no longer existed.

At the same time that Provident was breaching its legal and contractual obligations to pay claims as the primary carrier according to the MSP laws, on the other side, the underwriting side, it raised its insurance premiums to cover this additional liability that was imposed upon them by law. Many Provident customers complained because they realized that Provident was not making payment as primary and Medicare continued to make payment as primary, and they did not feel it was fair for them to continue to pay the increased premiums.

Senator ROTH. How much was the so-called surcharge?

Mr. BUSTAMANTE. The surcharges ranged from $55 to $75 per employee that was over 65.

Senator ROTH. Per month?

Mr. BUSTAMANTE. Yes, sir.

Senator ROTH. So how much was it a year?

Mr. BUSTAMANTE. Depends. I do not have the records or information, Senator Roth, to give you an estimate as to those figures. But the records, I believe, that the IG's office and the Justice Department gathered will yield that information to you.

Senator ROTH. But in other words, it was a significant amount of money?

Mr. BUSTAMANTE. Substantial.

Senator ROTH. If it is $75, that would be $900 a year per individual?

Mr. BUSTAMANTE. Per individual over age 65.

Senator ROTH. And they would also have to pay it for the spouse?

Mr. BUSTAMANTE. Yes, sir.

Senator ROTH. So this was a tremendous expense to the beneficiary.

Mr. BUSTAMANTE. It is. Yes, sir.

After receiving requests for refunds, Provident's justification in denying the request for refund was that someday the Government may find out about it and they would have to pay it back.

Perhaps one of the most flagrant abuses of the Medicare system can be seen in Provident's exchange of correspondence with some of its customers, including one of its largest customers, the Campbell Soup Company. I obtained a letter written in June of 1983 by the coordinator of employee benefits for Campbell's Soup Company. This was six months after the new law was initiated, Campbell's Soup Company realized that during the first six months payments had been made erroneously. That is, Campbell's Soup Company

through their group health plan had paid secondary instead of primary.

Provident administered that plan. Campbell's Soup Company wrote to Provident, asked Provident to develop a plan so that Campbell's Soup Company could do what the law required. That is, reimburse Medicare the funds that were erroneously paid out. The response that Provident sent to Campbell's Soup Company is as follows. "TEFRA does not require, and we do not suggest that anything be initiated regarding unsolicitated reimbursement."

Senator ROTH. Let me make sure I understand what you are saying, Mr. Bustamante. You are saying that Campbell's Soup on its own initiative wrote a letter to Provident making the case that they thought they were liable as a primary and not as a secondary carrier?

Mr. BUSTAMANTE. That is correct.

Senator ROTH. And that they wanted to meet that financial obligation?

Mr. BUSTAMANTE. Yes, and they wanted Provident to develop a plan so they could reimburse this money to Medicare promptly.

Senator ROTH. What was Provident's response?

Mr. BUSTAMANTE. Do not do it. Do not voluntarily reimburse any money.

Senator ROTH. What was the reason for that?

Mr. BUSTAMANTE. Well, obviously that is their policy. That is the policy they implemented.

Senator ROTH. What was said in the letter?

Mr. BUSTAMANTE. The letter specifically stated as follows, "TEFRA does not require, and we do not suggest that anything be initiated regarding unsolicitated reimbursement."

Senator ROTH. Is there anything in the law that suggests that being a shield?

Mr. BUSTAMANTE. Not in my opinion, Senator Roth. I think it is rather clear, the obligation is primarily placed upon the group health plan and those insurers that administer or insure those plans.

Senator ROTH. Please proceed.

Mr. BUSTAMANTE. Other letters exchanged between customers reveal hold harmless agreements that were entered into between Provident and the employers whose plans were insured or administered with Provident. These hold harmless agreements were obtained by Provident in an effort to seek indemnification from the employers since Provident recognized that it was their obligation to pay as primary and that their payment on a secondary basis violated Federal law.

Senator ROTH. What do you mean by a hold harmless agreement? What was the purpose of those agreements?

Mr. BUSTAMANTE. Provident agreed with the employer to violate the law. We will make payments on your working aged on a secondary rather than primary basis. However, before we will do so, we want an agreement from you, the employer, that if we get caught you will reimburse us back the money. That is, do not pay the premium now, but pay it to us later in the event that we are required to make the primary payment.

Senator Roth, I believe the evidence that has been presented and gathered by the Subcommittee and the investigators show that Provident avoided its obligation under the law and exploited the inadequacies of the Medicare system, all to the detriment of the taxpayers. Based on my experience I do not believe that Provident is the only insurance company that designed a policy of non-compliance. I have information that indicates these abusive practices may well have been the norm for several members of the insurance industry, at least when the MSP laws were first enacted by Congress.

Mr. Tomlin and I would be happy to answer any questions that you or other members of the Committee have.

Senator ROTH. Have you filed suit against other insurance companies in addition to Provident?

Mr. BUSTAMANTE. Yes, Senator Roth. We presently have five lawsuits pending. In addition to the Provident lawsuit there is a lawsuit pending against the Prudential Life Insurance Company of America. There is a lawsuit pending against Pan American Life Insurance Company. There is a lawsuit against Jefferson Pilot Life Insurance Company, and one against Blue Cross/Blue Shield of Georgia.

Senator ROTH. Now, on what basis do you, as a private practitioner, bring this kind of litigation?

Mr. BUSTAMANTE. Under the False Claims Act of 1986 as amended. It is a *qui tam* action which allows any citizen on behalf of the Government to bring a lawsuit when there is evidence of fraud against the Government. It is pursuant to that Act that those cases were filed.

Senator ROTH. Now TEFRA became effective in 1983. When did Provident decide to continue its policy of making secondary rather than primary payments as TEFRA required?

Mr. BUSTAMANTE. The first record reference to a decision was January 12, 1983, 12 days after the law was enacted. It was passed on to their adjusters on January 14, 1983.

Senator ROTH. Now financially, what effect does paying as secondary instead of primary have?

Mr. BUSTAMANTE. It is a two-fold effect. First of all, you have to understand what the insurance company's package or program is. Let me answer first by indicating, when you have an insurance company that actually issues a policy of insurance to the employer and the insurance company assumes the liability, the obligation to make that payment as primary by contract, in assuming that risk the insurance company charges a premium for that obligation.

So by paying secondary instead of primary after collecting a premium for that liability, there is a two-fold increase in their revenues. First of all, on the one hand they are taking additional income through the premium. On the other hand, the hand that is supposed to pay it out is not paying it out. So they are, as Mrs. Hillenbrand indicated in one of her letters, they are basically "killing two birds with one stone."

As far as the other insurance packages that they provide which are generally a self-insured type program, the employer creates a fund, either contributing or non-contributing depending upon the actual program, and then it is administered by Provident. The most direct benefit to Provident is that it places them at an advan-

tage over other insurance companies that are handling this particular Medicare Secondary Payer program correctly because they are able to reduce the expense to the employer, number one. And they administer it in such a fashion that it promotes the viability of their programs in the marketplace.

In addition to that, there are different levels of contribution which may be affected.

Senator ROTH. In other words, you are saying that by only paying as secondary under these so-called administrative programs, you reduce the cost to the employer so it makes you more attractive as an administrator than your competition who follows the law. Is that correct?

Mr. BUSTAMANTE. Yes, sir.

Senator ROTH. Now what is the significance of the surcharge, the additional surcharge?

Mr. BUSTAMANTE. The surcharge points out primarily that the company recognized its liability under the law. We are liable. We have a risk. We have to pay this money. So therefore, we are going to charge a premium for it.

Senator ROTH. In other words, when you change from a secondary to a primary payer you have additional liability, and that liability was covered by a surcharge.

Mr. BUSTAMANTE. That is correct.

Senator ROTH. What happened later? Was that surcharge continued?

Mr. BUSTAMANTE. Eventually, when the policies that were in effect came up for renewal, then they would incorporate that rating experience in the next renewal period so the surcharge would be eliminated. But the experience rating would follow to the extent that they made any payments. I do not have the financial information available to me to respond to any questions as to how they rated that program subsequently. That information has not been disclosed.

Senator ROTH. I would like you to examine Exhibits G and H, which are copies of form letters which Provident sent to persons who submitted claims.[1] What is the significance as you see it of these form letters? Are you familiar with individuals who have received such letters from Provident?

Mr. BUSTAMANTE. Yes. Senator Roth, Exhibits G and H are computerized form letters used by Provident to communicate with a beneficiary or provider. They are commonly referred to as a 001 letter and an 016 letter. In effect, what Provident is telling the beneficiary—let's assume the beneficiary incurs a bill, she is eligible for Medicare, she is a working aged—and sends the bill to Provident without any information referring to a Medicare payment.

Provident would then initiate, as Exhibit G shows, a letter which is known as an 001 letter asking the beneficiary to submit the bill to Medicare before Provident will consider it. In effect, it is asking the beneficiary to create a false record by sending the bill to Medicare first instead of Provident.

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[1] These exhibits were marked as Subcommittee Exhibit X and may be found on p. 236.

The second letter is a follow-up letter, an 016 letter which again serves the same purpose by telling the beneficiary or the provider that they will not make any determination on the bill until they get an explanation of benefits form from Medicare, which in effect is asking Medicare to pay first when Medicare has no obligation to pay first.

These letters were gathered through information that our law firm gathered as well as discovery. I have contacted and spoken in particular to the individuals to whom these letters were addressed. It is my belief and opinion that they do meet the qualifications under TEFRA, DEFRA and COBRA, and those individuals' bills should have been paid on a primary basis by Provident but were not. Instead, they were asked to send their bills back to Medicare on a first-time basis so that Medicare would pay it first and then Provident would pay the balance.

Senator ROTH. Now what are the dates of these letters?

Mr. BUSTAMANTE. I do not have them in front of me right now, but I believe one of them is in 1986 and the other one is 1984. G is 1984 and H is 1986.

Senator ROTH. The 1986 is the one that says, "since our plan is considered to be the secondary carrier"?

Mr. BUSTAMANTE. That is correct.

Senator ROTH. "All claims must be filed with Medicare first for benefit determination." Now why do you think Provident sent this letter?

Mr. BUSTAMANTE. It is clear, Provident wanted the beneficiary to send their bill to Medicare first so that Medicare would pay first, and then Provident would pay the balance that was due on the bill, which is paying secondary.

Senator ROTH. In other words, it is your claim that that was a way of getting Medicare to pay primary and they would pay the balance?

Mr. BUSTAMANTE. Exactly. As has been indicated by the subcommittee in its opening remarks, this entire system operates on the honor system. You must have a free flow of information from all sources, whether it be the hospital, the beneficiary, the provider, the employer, or the insurance company. As indicated by the Inspector General who just made the statement prior to my statement, the only source of that correct information is the employer and the insurance company, to the extent that they have all the data which would identify them as a working aged.

Senator ROTH. Let me ask you this question. Now in order to impose a surcharge on the working aged, and that is primarily who we are dealing with, Provident had to have information available as to who those working aged were; is that correct?

Mr. BUSTAMANTE. Yes, sir. Before you enlist or enroll in a group health plan you must submit to the carrier an enrollment card. That enrollment card gives identification of yourself, your date of birth, your Social Security number, your employment, your wages, your spouse and all dependents to be covered under that policy. That is the first document that is created by the insurance company to generate a particular risk.

Senator ROTH. To your knowledge, did Provident have this requirement?

Mr. BUSTAMANTE. Yes, every policy has enrollment cards.

Senator ROTH. Did they have this information on file?

Mr. BUSTAMANTE. Yes, some of it computerized.

Senator ROTH. If that information were available, could they determine by reviewing their records where they were required under the law to pay as primary?

Mr. BUSTAMANTE. Yes, sir.

Senator ROTH. Now we know that the taxpayers lose when insurance companies do not follow the MSP law. But what about beneficiaries, are there any possible problems for beneficiaries?

Mr. BUSTAMANTE. One particular problem that comes to mind, and was somewhat related to my client's situation although it did not evolve in that manner, but under Medicare there is a lifetime benefit that an individual has. Once you spend that lifetime benefit, you no longer can retrieve it. If someone is seriously ill and placed in the hospital for a considerable period of time you would absorb that lifetime benefit. If the group health plan did not pick up the hospital bill on a primary basis and Medicare picked it up, then that beneficiary would be subject to losing that particular benefit.

Senator ROTH. Let me make sure that this is clear. Under Medicare there is a limit to how much coverage you obtain. You have 60 days of full hospital coverage and 30 days of coinsurance coverage per year; is that correct?

Mr. BUSTAMANTE. Generally that is correct, and there is an additional element.

Senator ROTH. That is a one-time life benefit?

Mr. BUSTAMANTE. That is correct.

Senator ROTH. So what you are saying, that if you go to Medicare and use those 60 or 30 days up plus the life, you might be without coverage as far as Medicare is concerned?

Mr. BUSTAMANTE. Correct, for the life portion of it. Your 60 and 30-day increments would still be renewed after you have been out of the hospital for a period of time. But that lifetime reserve that you have is lost once you use it up. You do not regain that.

Senator ROTH. So from the beneficiary point of view, it is better that his coverage comes from the employer group plan because it does not expire?

Mr. BUSTAMANTE. That is correct. Besides that, he has paid good premium for it. He is being charged every month for it.

Senator ROTH. Now as part of your statement, you submitted a sworn statement from Anna Mae Hillenbrand, Exhibit J,[1] in support of your assertion that Provident was not paying MSP claims properly. Could you please identify this individual and briefly explain how this statement supports your allegations?

Mr. BUSTAMANTE. Ms. Anna Mae Hillenbrand is a classic example of a working aged beneficiary who has been taken advantage of because of the particular system implemented by Provident. Mrs. Hillenbrand happened to get sick in January of 1983. I believe it was like the 20th of January of 1983. She was a working employee for Macke Company out of Evansville, Indiana. She was over 65

[1] Marked as Subcommittee Exhibit X and may be found on p. 236.

years of age. She had routinely paid her premiums with Provident as a group carrier. When she went to the hospital she stayed for approximately two weeks, 10 days. Her bill came out.

Provident's, because of the memorandum that you observed previously today,[1] instructions were wait for Medicare to pay before we make payment. They did that in this case. Her bill was sent to both Provident and to Medicare. Medicare is the one that paid it; only paid a percentage of it. She had a balance left from the hospital. It was not being paid. So she eventually wrote out a check for that balance out of her own funds and complained to the insurance commissioner of the State of Indiana about Provident's practices.

After being confronted with Ms. Hillenbrand's correspondence, her bill, and the complaint from the insurance commissioner, all Provident did was turn around and pay the balance of the bill that had not been paid by Medicare instead of properly reimbursing Medicare for the entire amount that they were entitled to. This not only happened to Ms. Hillenbrand on one occasion, but it happened on several occasions. There is correspondence dated all the way into 1984 when she experienced basically the same thing, the same scenario.

Senator ROTH. Now you referred to a sworn statement by Edward Mitchell, Provident's assistant vice president of field claim operations, Exhibit M,[2] asserting that Provident owes an obligation to come forth voluntarily and reimburse Medicare on claims where Medicare paid as primary even though Provident should have paid as primary. To your knowledge, did Provident ever fulfill that obligation and voluntarily reimburse Medicare for these claims?

Mr. BUSTAMANTE. There is no apparent program implemented by Provident to do so. I am only aware of one instance where Provident claimed that they attempted to send the check back to Medicare, and that is the only instance that I am aware of. On all other matters that I have looked at and investigated, I have never seen that happen, and I do not believe that it was a pattern that they developed in any way.

In other words, they would not make any voluntary reimbursement to Medicare, not even when questioned by their own insureds, not even when questioned by insurance commissioners.

Senator ROTH. I only have a couple more questions. You made some reference to the logs presumably kept by Provident. Do you have any evidence as to whether these logs actually were maintained, and if so, what happened to them?

Mr. BUSTAMANTE. Yes, sir. The logs were maintained. First of all, there is record evidence to that effect. You have the original claim bulletin [3] which required the adjusters to maintain the logs. You have supporting evidence from Ms. Shelley's memorandum of March 5, 1985 [4] where she again expresses the belief that maintaining these logs are expensive and they should go ahead and make payment right away.

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[1] See Exhibit C on p. 206.
[2] Marked Subcommittee Exhibit CC and retained in the Subcommittee files.
[3] See Exhibit C on p. 206.
[4] See Exhibit P on p. 235.

But beyond that, I was able to gain through discovery testimony, including Mr. Mitchell, where he indicated as assistant vice president of claims for field operations, that the logs were routinely maintained and forwarded to the home office at Provident in Chattanooga. By the summer of 1986 when the logs were due to be produced, the information given of record was, they could not find any logs. Therefore, they have indicated that they were apparently either destroyed or they have been misplaced or disappeared.

To this day, there have not been any logs produced. The logs would have been the only easy method or record that would have been available to anyone to search back and compute the actual amount that was due and owing to the Government.

Senator ROTH. My final question is, do you have any specific recommendations based on your experience for changes either in the law or in the regulations?

Mr. BUSTAMANTE. Obviously, there are a lot of other folks that appear before you that are a lot more experienced than I am in regulatory matters and in the practical side of it. I can only speak from my experience and indicate to you that the system is an honor system. It requires a free flow of information. If anyone along that system is not willing to cooperate and join hands, they can take advantage of the system. What you see here today is a clear example of someone taking advantage of the system.

As far as what recommendations I can make to this Subcommittee, I do not have any direct recommendations. I only think, from my standpoint, is that the enforcement of the law should be pursued. You should not allow something to go on in excess of seven years without any direct enforcement or follow-up. As I indicated previously, my first letter to Congress was dated December 5, 1984. My last letter was November 2, 1987. And between those two dates I have numerous examples of letters to HCFA, to the IG's office.

I even have correspondence from the chief counsel of the Inspector General dated August 25th, 1986 indicating, "The information you provided us does indeed suggest that Provident's claims handling practices may be designed to avoid payment liability whenever possible. For this reason, I am forwarding your letter to the IG's office for review." Based upon what I have heard this morning, they did not do anything about it until March of 1988 when I filed my False Claims Act case, to investigate the matter.

So I think the system can work just like any other system can work on the honor system. But people have to comply with it. And to make people comply with it, you have to deter them from taking advantage of it. I think this system has been thoroughly abused, and in this particular case has been thoroughly abused by the insurance industry in certain instances by certain companies.

Senator ROTH. Thank you very much, Mr. Bustamante and Mr. Tomlin. Appreciate your being here.

Mr. BUSTAMANTE. Thank you, sir.

Senator ROTH. Our final witness today is Winston S. Walker, the president and chief executive officer of Provident Life and Accident Insurance Company. Mr. Walker has been with Provident for 16 years. We look forward to his testimony on the important issues before us.

We will take a 3-minute brief recess while they come forward.

[Recess.]

[Witness sworn.]

Senator ROTH. Mr. Walker, we appreciate your being here today. As I indicated earlier, I have read the prepared statements, including your own. It will be included in the record, so I would ask you to summarize your statement.

TESTIMONY OF WINSTON W. WALKER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVIDENT LIFE AND ACCIDENT INSURANCE CO.[1]

Mr. WALKER. I will be glad to, Senator Roth, and thank you so much. My name is Skip Walker, and I am the president and chief executive officer of Provident Life and Accident Insurance Company. I welcome the chance to be here with you today and I hope that Provident's experiences and recommendations will help this Subcommittee to think through Medicare's administrative problems. We can work together to improve the program.

I have been president and chief executive officer for 2 years now. Our company is among the 10 largest group health carriers in the United States. We are in the business of paying claims, mainly on behalf of our corporate customers whose health insurance plans we administer. Last year we paid nearly $3 billion in group health claims, more than 65,000 claims per day.

Let me briefly review the situation at Medicare. Until 1980 Medicare was usually the one who paid claims for everyone over age 65. If someone had additional coverage, that coverage was secondary and paid only what Medicare did not pay. Medicare processed the claim first, and only then did the second insurer even see the claim.

Beginning in 1980, changes to the law required that Medicare not pay primary benefits on certain types of claims if coverage was available elsewhere. In practice, for the first time that placed Medicare in the role of secondary payer, meant to come in only after other plans had assumed the bulk of the payments.

In 1983, a new law directed Medicare to no longer assume the role of primary payer for the working aged. At that time, Provident was prepared to pay claims on a primary basis for the working aged who are covered by our group customers plans.

Unfortunately, because Medicare had been the exclusive payer for so long, many beneficiaries as well as their doctors, the hospitals, and other health care agencies still continued to behave as if Medicare was the exclusive payer. Claims from these people continued to be sent first to Medicare.

Medicare's contractors also behaved as if they were the first payer on these claims. In many cases, they paid the primary amount of the claim without even checking to see if the insured had other coverage. In fact, even today Medicare does not have adequate systems or policies and procedures consistent with its role as secondary payer. Instead of sending the claims back where they belonged, Medicare just paid them.

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[1] See p. 150 for Mr. Walker's prepared statement.

So in the very beginning there was a lot of confusion as to how HCFA would implement the new law. We were first advised that there would be a delay on Medicare's part. We believed it was in the best interests of Medicare and our customers to coordinate with Medicare's payment strategy. You need to recognize that for most of these plans we were dealing with our customer's money and not our own.

Our thought was that like the procedures followed by Medicaid, HCFA would seek reimbursements in a timely fashion. In the meantime, we viewed our job to be the prompt and courteous payment of claims, but not overlapping Medicare.

As time went on and no guidelines came out, several attempts were made by our company and by our industry organization, the HIAA, to get more information from HCFA and its intermediaries how to proceed and how to attempt reimbursement to Medicare when they had paid primary. These efforts were rebuffed.

Over the years there have been at least 23 reports from various governmental agencies and officials, including your General Accounting Office, which criticized HCFA for its failure to adopt effective policies and procedures. These reports have offered suggestions how to do so. HCFA did not respond and time marched inexorably on.

So Provident became involved after the system had already failed twice. First, when claimants sent their bills to Medicare instead of to us. And second, when Medicare paid the bills without sufficient research.

As big as the problem seems to be, I believe there are effective solutions. First, amend the Medicare forms so that the claimant must either certify there is no other coverage, or else must attach an explanation of benefits from the private carrier.

Second, Medicare should coordinate benefits with the private insurance industry, the same way that Medicaid does, the same way that state workers' comp plans do, and the same way the health insurance industry has been doing successfully for many years.

We welcome guidance from the people responsible for implementing the laws that affect us and Medicare. We must have that guidance in order to do our jobs well. We ask: please help us help you. Bring us into the discussion. Let us offer a solution. Hear our recommendations. And let us know how to respond to the problems that continue today.

Insurance companies have a long and successful history of coordinating benefits among group health plans. This is because there are uniform procedures clearly understood by all and backed up by a spirit of cooperation and open communication. Medicare can succeed in the same way.

Thank you very much for your consideration and attention, and I would be glad to answer any questions you may have.

Senator ROTH. Thank you for your statement, and I appreciate the offer of cooperating in the future to try to straighten out what I consider a pretty serious problem.

Let me say that as far as your prepared statement is concerned, I would not argue that I think there has been a failing on the part of many. We will, of course, have HCFA before us tomorrow as well

as one of the hospitals. So we intend to look at that aspect of the problem.

But I guess where I have problems, Mr. Walker, is that you seem to suggest that Provident bears no responsibility at all for what I would call the Medicare Secondary Payer mess. In fact, if I understand your statement, you seem to be saying that Provident is not subject to the provisions, the early provisions of the MSP law. Is that correct?

Mr. WALKER. I cannot speak as an attorney. I am certainly not trained in that area.

Senator ROTH. We understand you are not a lawyer.

Mr. WALKER. But it is my understanding that the 1983 TEFRA law was directed at Medicare. It specifically mentions exclusions that Medicare should no longer pay primary in certain situations. I am not aware of any specific provisions of the statutes or the subsequent regs in 1983 that referred to insurance companies.

Senator ROTH. You say in your statement, "Neither are we as an insurer or administrator, subject to the statutory provisions which govern the Medicare cost." Yet that seems contrary, not only to what other insurance carriers and others considered to be the law, but even in your own internal memoranda. For example, I would just like to refer to a few of your memos. In a memo from Mr. T.J. Johnson, Jr.—he was a vice president? [1]

Mr. WALKER. Yes, sir.

Senator ROTH. To a Mr. Anzalone on July 11th, 1983.[2] "In answer to the question Phyllis says she is still getting about why Provident is making a surcharge if Medicare is still paying as primary, the simple answer is that we are legally obligated for primary benefits back to January 1st, 1983, and the Federal people can come after us for additional payments in cases where we paid secondary." It then goes on later to say, "However, it seems to me we have got to live with this as best we can, and where we are asked about the surcharge, make it clear that we are legally obligated for primary benefits as of January 1st, 1983."

Let me go on and read you some others. In a memo to a Don Reardon, Charlie Griffith, September 13, 1983,[3] "Dear Don"—in the third paragraph—"The law is very clear in that we have liability as primary carrier beginning January"—and you cannot read the rest of the date—"1983."

I will read one more. The record is replete with this. This is to Provident's group policyholders, Tax Equity and Fiscal Responsibility Act of 1982, December 1982.[4] "Under the new requirements of the law, the Provident health plan must pay benefits for active employees"—no qualifications—"must pay benefits for active employees age 65 through 69, and for their dependents age 65 through 69, without any regard to any benefits to which the employee or dependent might be entitled under Medicare." I underscore that last part, "without regard to any benefits to which the employee or dependents might be entitled under Medicare."

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[1] See Exhibit F on p. 209.
[2] See Exhibit G on p. 210.
[3] See Exhibit K on p. 223.
[4] Exhibit B on p. 205.

Now let me ask you, Mr. Walker, do you have a legal department?

Mr. WALKER. Yes, we do.

Senator ROTH. How many lawyers do you have there?

Mr. WALKER. We have quite a large number. I do not know exactly. It would be 20 or so.

Senator ROTH. 20, 30, 40?

Mr. WALKER. Yes.

Senator ROTH. But do you have a qualified law department that purportedly advises you on such matters, is that correct?

Mr. WALKER. We have a qualified law department and they would normally be in appropriate contact with the people involved with administrative matters.

Senator ROTH. I go back to my question. I find it very difficult to follow your reasoning that the statute has no impact on you when your own internal documents, and I assume that they must have been issued with the advice of counsel, indicate otherwise.

Do you assert that current MSP law does not require you to do anything when you learn that Medicare has erroneously paid a claim for one of your insured?

Mr. WALKER. It is my recollection, Senator Roth, going back to your earlier concern that indeed our company was quite prepared to pay on a primary basis from the very beginning. I think some of the questions that you raise are really coming up as consequences to difficulties that we discovered very early on with Medicare contractors not being prepared to pay on a proper basis.

Senator ROTH. I understand the thrust of your prepared statement of blaming the other fellow, and I think there is some blame to be accepted there. But what I am really curious about is what was the responsibility of Provident itself? Again, let me point out, you did impose a surcharge, did you not?

Mr. WALKER. Yes, sir.

Senator ROTH. What was the purpose of the surcharge?

Mr. WALKER. The surcharge is a matter that affected part of our business, certainly not the entire block of business that we had been involved with. The surcharge is applied to roughly 10 to 15 percent of our business. As a consequence, the vast majority was not involved with it.

I think it is important, in the way of background, to recognize that we pay these claims with customer money. These surcharges would have been typically on small case business and would have been in place for only a brief period of time. We make our profits by pooling risks and by providing services, and we would have expected a bit higher claims experience as a result in the changes in the Medicare laws.

Senator ROTH. Let me interrupt if I may. You have what you call retention business and I guess non-retention business. Now the one area where it is very obvious that the surcharge makes a difference is the so-called non-retention business. Is that correct?

Mr. WALKER. The non-retention business was the primary place we put surcharges and it constituted about——

Senator ROTH. That is the straight insurance and if you have to pay more than the premiums, you suffer a loss, is that correct?

Mr. WALKER. Yes, sir, that is correct. That is fully insured business.

Senator ROTH. That is roughly 12 or 15 percent of the business, is that correct?

Mr. WALKER. That part of our business would be close to 10 percent of our business.

Senator ROTH. You have what you call a retention, which includes maximum payment. Did you charge those people, under the maximum payment? Did they pay a surcharge?

Mr. WALKER. I am not familiar with the term maximum payment. We do have a large block of business called——

Senator ROTH. This is a document submitted to me. It says "Under MPP plans, Provident insures the employer's obligation to provide group health benefits only above a substantial level called an attachment point. All benefits below the attachment point are paid with the employer's funds. All benefits above it are insured and paid by Provident."

Are you familiar with that?

Mr. WALKER. Yes, sir. Those are called minimum premium plans.

Senator ROTH. I am sorry, I said maximum. Minimum, you are correct.

Mr. WALKER. My understanding is that surcharges were not normally associated with that block of business.

Senator ROTH. Are you sure that was not the case?

Mr. WALKER. I would be glad to have someone check on that. I was not part of that operation and cannot answer based on my own personal experience.

Senator ROTH. We may have some additional questions we will ask you to submit answers to in writing.

Let me point out the surcharge was quite substantial for those that had to pay it, is that correct?

Mr. WALKER. My recollection is that the surcharge ranged between $50 and $75 per month for the——

Senator ROTH. I have a memo here,[1] because I think it is important to understand that certainly to the beneficiary, or the one who is covered, this represented a very significant amount of money. As I understand what your surcharge was, a surcharge of $75 per month, that is $900 annually, for each employee or dependent who is aged 65 to 69. So if a man and his wife are in that age bracket and one of them is employed, they would have to personally pay $1,800 a year? Is that correct?

Mr. WALKER. No, Senator, that is not my understanding at all.

Senator ROTH. Let me say, this is a letter from Mr. Steve Carter to Mr. Bruce Brown, group department.[2] This is February 8, 1983. "Currently, we are making a surcharge of $75 per month ($900 annually) for each employee or dependent who is aged 65 to 69." Are you saying that is incorrect?

Mr. WALKER. I am not familiar with that memo. I would take at face value what it says, but I think the confusion here, Senator Roth, is that the employees do not pay this surcharge. This is an amount of premium paid by the employer as part of his group

[1] See Exhibit B on p. 205
[2] Ibid.

health plan. I thought you had asked about people paying out of their own pockets, the surcharge.

Senator ROTH. Let me read on. The next sentence in this memorandum says "In addition, a regular premium is being charged for them to the employer, which typically ranges from $35 to $70. This means that we are typically charging our customers around $1,320 to $1,740 per person." That is a pretty significant amount.

Would it vary by employers and plans as to who might pay that?

Mr. WALKER. My understanding is that virtually all of these plans would be paid by the employer and not the employee. That is the basic thrust of an employer sponsored group health plan.

Senator ROTH. In any event, it is a very healthy kick up in health costs, for whoever paid it, whether it is an employer or employee, is that not correct?

Mr. WALKER. Frankly, sir, it is a matter of perspective. Today, for example, typical health costs for a covered individual run on the order of $3,000, perhaps $3,200 a year. These costs would normally be expected to be even higher for aged employees.

Senator ROTH. The point I am making here is that your surcharge, irrespective of who paid it, was very substantial for each of these so-called working aged, those between 65 and 69. It was between $1,320 to $1,740 per person. That is a significant increase, even by those figures. Would you not agree?

Mr. WALKER. I am just, frankly, not comfortable characterizing these surcharges as significant. I have no reason to believe, for example, that they were adequate to cover the costs of the claims.

Senator ROTH. Let me say, in my judgment, it is a significant amount per person.

Let me go on to the next question, however. That increase was to cover your additional exposure or liability by the change in the law is that correct?

Mr. WALKER. It would have been expected to cover higher claims experience. In fact, the early administration of these claims, following on the heels of Medicare mispaying the claims, was one of paying and expecting to reimburse Medicare on request. This was a procedure that we had commonly followed with the Medicaid organization. It had worked well with them. Certainly our expectation was that Medicare would take the same approach.

So indeed we expected to make higher claim payments. We did make higher claim payments through that period.

Senator ROTH. In your memorandum that I made reference to earlier, including the one to your Provident Group policy holders, you say that "Because of the additional liability under the Provident Group health coverage on active employees and their dependents aged 65 to 69, a surcharge of $55 will be added."

So time and again, as I mentioned, you obviously felt there was increased exposure that had to be covered by this surcharge. Subsequently, how was this surcharge adjusted to incorporate Provident's increased exposure?

Mr. WALKER. These surcharges applied only for a short period of time, certainly less than a year.

Senator ROTH. And what happened afterwards? That is the thrust of my question.

Mr. WALKER. Subsequent to that, I am not aware of any surcharges being made on plans.

Senator ROTH. But rather than have a surcharge, the premium rates were adjusted to take into account the increased liability of providing medical care, is that not correct?

Mr. WALKER. I would expect that was true, yes, sir.

Senator ROTH. Is it or is it not? You are the president.

Mr. WALKER. Again, I was not part of that department at that time, and so cannot comment on the specific approaches. Certainly, the normal way that pricing policy would have been done would be to review experience on blocks of cases and to make premium rate adjustments, depending on the costs of the care being provided.

Senator ROTH. Just let me read again from this memo of December, 1982 to Provident Group policy holders. "The surcharge will be continued until the billed premium rates for your group plan are adjusted to take into account the increased liability of providing medical care benefits for those active employees and dependents on a primary basis."

So that certainly puts your policy holders on notice that the premiums will be adjusted upwards to offset this increased exposure. Is that a fair statement?

Mr. WALKER. There is no question but that we expected to pay benefits on a primary basis. When it turned out that that seemed to be problematic in terms of the payment strategy that Medicare had undertaken, we applied very deep and long standing fundamental insurance principles, which involved the need to avoid duplicate payment of claims.

We felt there was certainly no interest to be served when a provider or beneficiary would be reimbursed on a primary basis, both by Medicare and our company. And as a result, we had adopted a procedure to pay in a fashion complementary to Medicare and expect reimbursements from the Medicare contractors.

Over the years, we in fact did make reimbursements. To the best of my knowledge, every valid request for reimbursement has been honored and the result of this is that the affected plans would have ultimately fulfilled their obligations.

Senator ROTH. Let me refer to a memorandum written by Marilyn Shelley to Dana Reynolds, dated March 5, 1985, exhibit P [1] Ms. Shelley states that "In her opinion, Provident claims instructions 'create a violation of federal law.' "

Ms. Shelley testified in a Subcommittee deposition that she wrote memos twice seeking a response to this question and that no one ever responded to her assertion. Why did no one at Provident respond to an employee who, in the course of performing her responsibilities, asserted that claims instructions created a violation of federal law?

Mr. WALKER. Senator Roth, it is my understanding that portions of this document are privileged and we certainly do not want to waive our privilege and I would prefer not to comment on those portions of this specific memorandum.

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[1] See Exhibit P on p. 235.

However, like many internal memorandums, this does show that our front-line employees were struggling with the Medicare situation. I believe Ms. Shelley has also discussed with your staff that this particular memorandum assumed that group claims bulletin 83-1 [1] was still operative and that she was unaware that it had been revoked by a later group claims bulletin. It is also my understanding that had she known that, there would have been no need for this particular memorandum.

Indeed, her questions raised here were responded to and acted upon and I believe that is part of the ongoing review of our claims payment policies that took place through these years.

Mr. RINZEL. Mr. Walker, whatever the issue is about, the privilege or non-privilege, I think the question is what, if anything, was done about this memorandum internally at Provident? Marilyn Shelley testified in a deposition that no one ever responded to her.

Do you have information that something was done about the memorandum?

Mr. WALKER. It is my understanding that her supervisor, Dana Reynolds, indeed took this memorandum under advisement and did respond. The conclusion at that time, as best I recall, was that the current practices of paying claims were indeed proper. They fell within the requirements of TEFRA and, in fact, the approach of expecting to be requested for reimbursements by Medicare was the normal Medicare administrative practice at that time.

Mr. RINZEL. In other words, as a result of this memo, there was no change made in Provident practices? That is, Provident continued to pay secondary when you had evidence that Medicare had already improperly paid primary and you were waiting for Medicare to come to you to ask you about reimbursement? You had no intention of taking any affirmative action to approach Medicare and advise them that they had paid improperly, even though you knew that they had? Is that a fair statement?

Mr. WALKER. I do believe that, in fact, the requirements lay on Medicare to pay primary and there were no specific requirements, either in the statutes or the regulation, for Provident to take unilateral action in terms of coming back to Medicare.

On the other hand, it is the case that we did approach Medicare on occasions, not only through our customers, but our company as well as through our trade organization, HIAA, and these efforts seem to have no fruit.

Mr. RINZEL. But your claims examiners, your people on the street so to speak, were following the company policy of simply paying secondary when they became aware that Medicare had erroneously paid primary on one of your insureds, is that not correct?

Mr. WALKER. It is my understanding that in cases where we recognized that Medicare had already made an improper primary payment, that we would pay on a secondary basis and expect reimbursement.

Senator ROTH. Even though you have a number of internal statements recognizing that you had a liability as primary?

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[1] See Exhibit C on p. 206.

Mr. WALKER. I think there are two points here that are important.

Senator ROTH. Let's stick to the question. You have a number of internal memoranda admitting your liability as primary, that the purpose of the law was to change Medicare from primary to secondary.

Mr. WALKER. Yes, sir, there are a number of internal memoranda. Often these memos are phrased in a shorthand form.

Senator ROTH. We read those. One was from a vice president, Mr. Johnson.[1] There was nothing shorthand about it. It was very clear-cut that you had primary liability.

Mr. WALKER. I believe the shorthand part that I am referring to, Senator, has to do with the statement about Provident being obligated to pay primary or secondary, when in fact it is the plans that we are responsible for administering that indeed are involved here.

Senator ROTH. Now did your plans say that you could exempt the payments that were made by Medicare?

Mr. WALKER. I cannot answer that question. I do not——

Senator ROTH. See, you are trying to have both sides of the coin. One moment you say, the law establishes no obligation on your company even though there are internal memoranda to the opposite. On the other hand, you want to say you had no obligation under your plans to pay according to the plans because of what Medicare paid. So you are taking advantage of Medicare to save your company money. Is that complying with the law in good faith?

Mr. WALKER. I really cannot accept the premise that we were in the business of taking advantage of Medicare. We were faced really with three possible responses to these errors. First, even in cases where we recognized Medicare had paid primary, we could go ahead and pay primary also. Our concern here, of course, was——

Senator ROTH. Let me say what bothers me. First of all, you have got any number of internal memoranda, to which I referred, written by high-ranking officials of your company. I think you would agree Mr. Johnson was a high-ranking official.

Mr. WALKER. Yes, sir.

Senator ROTH. Admitting liability under the changed law. Secondly, you have a surcharge between $1,300 and $1,700 a year, to cover that exposure. A very substantial amount of money for each of the beneficiaries. But when it comes to making any payment, you do not make the payments for which this exposure was intended to cover. It appears to me that you hide behind the screen that Medicare paid it.

Now I find that a very difficult line of reasoning to follow as a means of complying with the law in good faith. Now as I understand it, Provident was saying that you would wait for Medicare to come to you before you would pay what you were supposed to pay. And now you say you have no records and do not know what you owe. Is that correct?

Mr. WALKER. I do not recall making any comments about us having no records.

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[1] See Exhibit F on p. 209 and Exhibit G on p. 210.

Senator ROTH. At one time there were instructions to maintain logs so that if Medicare came back and asked you to reimburse them for improper payments that you would have records; is that correct? Do you recall those logs?

Mr. WALKER. I do—some reference to a need to keep logs. This would have applied very early in 1983, and then about midway through——

Senator ROTH. Let me make two observations. Yes, it is true on January 18th, 1983 you said—Phyllis O'Connor wrote to all adjusters,[1] "Subject: Medicare. From now on, let's keep a log of all Medicare claims paid for expenses after January 1st, 1983." We have that exhibit in front of us.

Line 3 of the Shelley memorandan dated March 5, 1985 says, "Time and loss and aggravation in maintaining a manual log of these claims." [2] So in 1985, presumably you were still keeping these logs.

So I go back to my question. As I understand it, Provident was saying that you would wait for Medicare to come to you before you would pay what you were supposed to pay, and now you say you have no records and do not know what you owe. Is that correct?

Mr. WALKER. I do not know the extent to which systematic or specific logs were kept, Senator Roth. I do understand that one of our company people has filed an affidavit specifically discussing findings with regard to these logs. In terms of this memorandum, again, Ms. Shelley is writing this on the assumption that Group Claim Bulletin 83-1 applied, and it did not.

Senator ROTH. Does that statement you make reference to not say that the logs do not exist—affidavit of Tim Bolden? [3]

Mr. WALKER. I am not familiar with the details of that affidavit. I would be happy to supply you with a copy of it.

Senator ROTH. I think we may have it here. Does the absence of records suggest that Provident thought there might be at least a chance that Medicare would never seek reimbursement?

Mr. WALKER. I am not aware of any policy or decisions that were made assuming that Medicare would never seek reimbursement.

Senator ROTH. Mr. Walker, you are a multi-billion dollar company; a very large, substantial insurance company. You have a very large legal department. I assume you have a very substantial accounting firm.

Now when the law was changed back in the early 1980's, your company apparently felt it was necessary to immediately impose a surcharge to take care of this potential exposure, this liability. At that time there were instructions issued to maintain logs of money owed to Medicare. It seems strange, paradoxical to me, that a large company of your size did not maintain records of a potential exposure of this type.

Where was management at this time? You are chief executive officer now as I understand it. What would be your advice now as to this situation? Would you require that there be logs maintained so

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[1] See Exhibit H on p. 211.
[2] See Exhibit P on p. 235.
[3] Marked as Exhibit Z and may be found in the Subcommittee files.

that if there was an exposure you would be able to state what the facts are?

Mr. WALKER. It is difficult for me to put myself back in the shoes of the individuals at that time.

Senator ROTH. Again, let me ask, you are chief executive?

Mr. WALKER. Yes, sir.

Senator ROTH. This could be a very substantial exposure, could it not, to your company as a result of the change of law. Is that correct?

Mr. WALKER. I do not believe that the exposure that Provident faces here is an unusually large one.

Senator ROTH. Yet you charge a $1,500 premium, additional premium, additional surcharge for every working aged. I tell you, there are not many beneficiaries that would not think that was a significant change. You are telling me that in today's world in modern accounting practices that you would not require records to be kept of this potential when you found it necessary to impose that kind of a surcharge?

Mr. WALKER. Again, I think the need to keep logs is really dependent on other aspects here. The Medicare policy of paying and then seeking reimbursement certainly did not put any responsibilities on our part to keep logs. The difficulties that prevail there regarding these logs is that we have no guidance or procedures as to how to approach these circumstances where Medicare has paid.

Senator ROTH. Mr. Walker, businessman after businessman comes to me and complains about over-regulation. That there are too many regulations, they are too difficult to understand, and that they are unnecessary. As a result, in the years past I have voted time and again and led the fight in many cases to deregulate. Now you are coming here before us and saying, because there was no specific regulation requiring this you had no obligation to do it, even though in your own internal memoranda you admit that there was at least potential exposure if not outright liability.

Now that raises a serious question of operating in good faith, in my judgment, and makes it very difficult for those of us who have been trying to support deregulation, including the insurance business, to support that kind of situation. There is no question, in my judgment, what the law intended to do, and your memoranda clearly indicate that.

Let me ask you this. Exhibit M [1] includes documents indicating that Provident entered into hold harmless agreements with employers whose plans were insured or administered by Provident. According to these agreements, Provident sought indemnity from these employers in the event that Medicare sought reimbursement from Provident for claims which should have been paid primary to Medicare. Now would you describe the circumstances of these hold harmless agreements?

Mr. WALKER. I am not familiar with—are you talking about exhibit M of my prepared statement, sir?

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[1] See Exhibit M on p. 228.

Senator Roth, I have not seen this material before and, for example, I cannot tell at quick glance whether this applies to one of our ASO type customers or minimum premium type plans or what not.

Senator ROTH. We will submit the question in writing and you can supply it.

Mr. WALKER. I would be most happy to.

Senator ROTH. Is it true that when TEFRA became effective, January 1, 1983, Provident instructed its employees to take no action on claims submitted for primary payment until Medicare had reviewed the claim?

Mr. WALKER. You are asking about the claims policy in the first part of 1983?

Senator ROTH. That is correct.

Mr. WALKER. My understanding is that our initial claims policy was, in fact, to be prepared to pay primary on behalf of our customers. When we discovered Medicare was also paying primary, our policy was to contact the Medicare intermediary and find out whether they were prepared to pay primary or secondary.

In the event that they were prepared to pay secondary, we would pay on a primary basis. If, on the other hand, the contractor was not yet in a position to pay secondary, they would be paying primary and we would pay secondary at that time.

Senator ROTH. I have two letters here.[1] A reference has been made to them earlier. I would like to ask you to look at them. These letters state that "Our files indicate that the patient above is also covered by Medicare. Since our plan is considered to be the secondary carrier, all claims must be filed with Medicare first for benefit determination and payment. At that time, please send us a copy of the payment explanation for Medicare." That is the one letter which presumably was in effect in 1986.

And then we have one dated 1984 which again goes to the claimant. It says "We are unable to complete the correct processing of this claim until we have received a copy of the explanation of benefits paid by Medicare." Is that a standard form?

Mr. WALKER. Yes, sir. This looks to be a standard computer generated form and I would expect that this was used to deal with claims where the claimant would be covered by Medicare on a primary basis. Of course, our plans cover a number of people, retired employees for example, and they would expect to be covered by Medicare primary.

The intent of this form, seems to me, to address the situation where a claim was submitted to us where indeed Medicare was supposed to be primary and we would send this back in order to get the claim back into the right channels.

Even today, the vast majority of claims submitted by aged people covered by our plans——

Senator ROTH. Let me ask you this question. You knew who to impose a surcharge on. Why could not you have developed, in your company, the information as to who fell within the working age group, so that you could make this determination yourself?

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[1] See Exhibit X on p. 236.

Mr. WALKER. You may be surprised to learn that in the group business, in fact, the insurance carrier or the administrator does not, indeed, know all the people that are covered by the plan.

Senator ROTH. The employer knows.

Mr. WALKER. The employer certainly knows who the employees are. The employer would know those covered by the plan. That information does not come normally to the insurance company until a claim is submitted.

Senator ROTH. But your client, the employer, would know, is that not correct?

Mr. WALKER. I would expect so.

Senator ROTH. He is the employer of the employees who work there, so is it not yes?

Mr. WALKER. Yes.

Senator ROTH. Why could you not get that information then, so that you could comply with the law and determine in what cases you were the primary payer?

Mr. WALKER. The information that we needed, as a claims processor, does not include an entire census or roster of employees. As administrator of——

Senator ROTH. That was my question. You could obtain that information if you wanted to, from the employer. That could have been a condition of your contract, couldn't it?

Mr. WALKER. Indeed, that is not done in the group business. That is not part of the kind of services——

Senator ROTH. But now you have a requirement to comply with the law. And as we have already said time and again, it was clear to everyone that the purpose of the law was to make the employer group health plan the primary payer and Medicare the secondary. It seems to me that there was a good faith obligation on the part of the insurers to obtain whatever information was necessary in order to comply with the law.

As I said, it is paradoxical to me that you were able to know who to impose the surcharge on for the additional fees.

Now we have spoken to other insurance companies who did not share the confusion that Provident claims to have about its legal responsibility to pay claims as primary to Medicare. These companies approach MSP very differently than Provident.

For example, John Hancock Mutual Life Insurance Company, among others, implemented vigorous programs to train its employees on the changes and procedures required by TEFRA, the working elderly law. Also, when Medicare made apparent erroneous primary payments on behalf of beneficiaries insured by John Hancock, the company advised us that after checking with the employer, they regularly reimbursed Medicare for the incorrect payment.

But you say Provident was unable to do this?

Mr. WALKER. I believe we also reimbursed Medicare for improper payments. We would reimburse on request. We attempted on patients——

Senator ROTH. You made no payment unless there was a request, is that not correct?

Mr. WALKER. We did make efforts, on occasions, to——

Senator ROTH. On occasion. You keep using the word on occasion. How many occasions?

Mr. WALKER. I cannot give you a count, of course. The efforts that we undertook to reimburse——

Senator ROTH. You do not know either, because you say you do not have the logs.

Mr. WALKER. The logs really do not deal with the efforts to reimburse Medicare. These efforts were unsuccessful on our part. I refer to exhibit G in my prepared statement where, in fact, we sent checks to Medicare and they were returned to us. Medicare was not in a position to accept these monies.

It is apparent to me, with the benefit of hindsight, that nothing that we could do at Provident would make Medicare pay correctly. In terms of understanding the law, we finally reached such a high level of frustration that we felt it was necessary to file suit for declaratory action in court. I also note that the government found it necessary to get clarification of the law.

I am hoping that those issues indeed will come out with answers soon.

Senator ROTH. Let me go back to the Campbell Soup case. Are you familiar that Campbell Soup came back to your company for instructions, that they believed that they owed money because of Campbell's primary liability and Medicare's secondary?

Mr. WALKER. I an aware that Campbell Soup is a customer of ours but I do not have any experience or detail about the handling of their account.

Senator ROTH. They write in that letter, "I would like to clean up this situation as soon as possible." And it goes on to talk about their primary responsibility.

We have a few more questions, Mr. Walker.

Provident replied, in exhibit L, that TEFRA does not require and we do not suggest that anything be initiated regarding unsolicited reimbursement. The whole thrust of the company policy is seen to be to hide behind the lack of any request for reimbursement knowing full well that, in many cases, Medicare did not have adequate information. With that, I agree with your opening statement.

Why did you advise Campbell Soup not to do anything?

Mr. WALKER. Again, sir, I apologize for not being familiar with the details specifically of Campbell Soup. I would be most happy to have some of our technical people back in Chattanooga research that case, research that correspondence and give you an appropriate response, sir.

Senator ROTH. As I understand it, Provident was saying that you would wait for Medicare to come to you before you would pay what you were supposed to pay, and now you say you have no records and do not know what you owe. Is that correct?

Mr. WALKER. Sir, it is my belief that, in fact, we have paid amounts that we owe. It has been our policy for many years to pay every claim that we owe. That remains our policy and will be the policy in the future. The situation regarding Campbell's Soup is something that I would have to have some of our people dig into.

Senator ROTH. Of course, you have instruction after instruction that you will not pay unless there is a request for reimbursement. Do you have a question?

Mr. RINZEL. Yes, Mr. Chairman. I wonder if we could get exhibit F up? This is a particular document, Mr. Walker, it is a memo

from T.J. Johnson, Jr. dated January 12, 1983.[1] I am curious about it because I think it is the earliest document that we have found dealing with the question of reimbursement.

This memorandum from Mr. Johnson states that "Blue Cross of Tennessee has notified American Enka in Lowlands, Tennessee—" and I understand American Enka was one of your company clients "—that Medicare administered by Blue Cross of Tennessee will continue to pay claims on active employees ages 65 to 69 and their dependents on a primary liability basis for the first few months of 1983, as there will be a delay in implementation of the TEFRA amendments."

As I understand it, American Enka in addition to being your client, was also a client of Blue Cross or that Blue Cross had some kind of administrative relationship with American Enka. Do you understand that to be correct?

Mr. WALKER. I do know that at one time American Enka was a customer of Provident's. As I look at this memorandum, it looks to me that Blue Cross is playing two roles. It is possible that both Provident and Blue Cross were involved as a group carrier. But I notice here, from the memorandum, that Blue Cross is playing the role of Medicare administrator. Provident has never been a Medicare contractor or a Medicare administrator, so we would not be familiar with the problems that Blue Cross was having here as administrator.

Mr. RINZEL. That is correct, but the memo indicates—and what I am asking you is whether my interpretation of this memo is correct—that Mr. Johnson discovered that Blue Cross of Tennessee was going to continue to pay secondary on claims from American Enka, and they advised American Enka of that. Since Blue Cross of Tennessee was also the intermediary, they had control of both ends of the process, and they were going to continue to pay primary in their role as Medicare intermediary. That is the way I read it. Do you think that is a fair reading?

Mr. WALKER. That is what it looks to me, and this amazes me as much as it does you. It looks like here we have a situation, Blue Cross of Tennessee, which has both sides of the package here, and I do not have a good understanding of why they are having difficulty communicating internally. I am non-plussed by it.

Mr. RINZEL. Anyway, the information Mr. Johnson had received indicated that Blue Cross was not going to implement this new requirement for primary payment and that they were going to continue with the old system. And then he goes on to say in the memo "In other words, we should not automatically assume the Medicare intermediary is going to pay as secondary, but we should find out whether Medicare is going to pay as primary or secondary in a given case."

Am I reading this memorandum correctly that Mr. Johnson feared that you, Provident, were going to be put at a competitive disadvantage if Blue Cross was continuing to pay secondary and Provident began to pay primary? Was he concerned about not

[1] See Exhibit F on p. 209.

being put in that kind of disadvantageous position? Is that a fair interpretation of this memo?

Mr. WALKER. I do not agree with that, Mr. Rinzel. First of all, I do not read anything in here that talks about Provident being at a competitive disadvantage. It seems to me that the thrust of this memo deals with the handling of claims and certainly some surprise and concern on his part that a major Medicare intermediary was not prepared to implement the new law that applied to them.

Mr. RINZEL. I would agree that it does not say anything in the memo precisely about a competitive disadvantage, but the fact would be that if both Provident and Blue Cross are servicing this company and Blue Cross is going to be paying, in effect, only 20 percent of the claims on behalf of the company and you're going to be paying 80 percent of the claims, the company's costs under your administration of their plan is going to go up considerably but is going to stay down for Blue Cross, and that puts you at a competitive disadvantage.

After all, if you are the company official and you see what is happening, you are going to say Blue Cross is doing a better job for us than Provident, so let us drop Provident and go to Blue Cross. Is that not a possible result?

Mr. WALKER. I do not particularly follow why Provident would be at a competitive disadvantage.

Mr. RINZEL. Because the costs of the plan you administer for this company would go up dramatically because you are now paying 80 percent whereas Medicare previously paid 80 percent. And if Blue Cross is still only paying 20 percent on the part of the plan that they administer for the company, their costs stay down.

Mr. WALKER. In the vast majority of our cases, it is the customer's money that we are paying with, and therefore it would not make any difference in terms of competitive structure.

Mr. RINZEL. It is going to make a difference to American Enka because the money comes out of their pocket, and you are the administrator of the plan. And American Enka says I do not know what is happening here, but you, Provident, are not doing a very good job for us. We are paying a lot more. And they are paying less. Is that not a fair statement?

Mr. WALKER. I just do not agree with your conclusion here, Mr. Rinzel.

Mr. RINZEL. Thank you, Mr. Chairman.

Senator ROTH. I think we are coming to the close. One final question.

The General Accounting Office has recommended that Congress adopt the House proposal to establish the government's right to collect twice the amount owed from insurers that do not properly treat Medicare as secondary payer. Do you think that this would help administer the law in a more equitable and fair manner?

Mr. WALKER. I think the solutions that we outline in the statement here are important pieces to build a foundation on. The question of giving proper incentives to Medicare administrators is indeed a big one. I think insurance carriers can indeed be very helpful in terms of correcting these issues. We believe that the coordination of benefits is the way to go, the openness of communication, the fix at the front-end.

I would be hopeful that a long-term solution would be based on those principles.

Senator ROTH. What I was talking about here really was a penalty on the insurers, not an incentive to the intermediaries.

Mr. Walker, just let me close by making the comment that I think, without drawing any final conclusions, that it does raise some very serious business questions where a company, an insurer, continues to pay as a secondary payer; imposes first a very substantial surcharge to cover a potential liability; then works it into the premium rate; apparently keeps no records of the working aged; and relies on the fact that Medicare records are inadequate to collect reimbursement.

I think Provident maintained a series of policies that are very protective of the financial interests of the company and disregarded its legal liability and its contribution to the increased cost of health.

I appreciate your being here today, Mr. Walker, and do hope that the industry will work together with government in trying to resolve these difficult problems.

The Subcommittee is in recess until 10 o'clock tomorrow here in room 342. We will hear testimony from Gail Wilensky, head of the Health Care Financing Administration; as well as from Johns Hopkins Hospital and Blue Cross Blue Shield of Maryland, the Medicare contractor for Maryland and Washington, DC.

The Subcommittee is in recess.

[Whereupon, at 12:29 p.m., the Subcommittee recessed, to reconvene on Thursday, July 12, 1990.]

HEALTH CARE FRAUD/MEDICARE SECONDARY PAYER PROGRAM

THURSDAY, JULY 12, 1990

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room SD-342, Dirksen Senate Office Building, Hon. William V. Roth, Jr., presiding.

Present: Senator Roth.

Staff present: Eleanore J. Hill, Chief Counsel; Mary D. Robertson, Chief Clerk; R. Mark Webster, Investigator; Cynthia Comstock, Staff Assistant; Kimberly O'Dell, Staff Assistant; Daniel F. Rinzel, Minority Chief Counsel; Stephen Levin and Janet Rehnquist, Minority Counsel; Mary K. Vinson, Minority Chief Investigator; Sallie Cribbs, Minority Executive Assistant to Chief Counsel; Carla Martin, Minority Assistant Chief Clerk; and Blaine Phillips, Minority Staff Assistant.

Other Staff: Ellice Halprin Barnes and Norman Lorange (Senator Stevens); and Bobby Franklin and Bonnie Hogue (Senator Pryor).

OPENING STATEMENT OF SENATOR ROTH

Senator ROTH [presiding]. The Permanent Subcommittee on Investigations will be in order.

Our distinguished Chairman, Senator Nunn, is unable to be with us here this morning due to his commitment as Chairman of the Armed Services Committee.

I am grateful to the Chairman for calling these hearings on the Medicare Secondary Payer program, better known as the MSP program.

We both share a strong interest in and commitment to eradicating abusive practices in the health care industry which are costing the taxpayers billions of dollars. As we heard yesterday, beginning in 1980, Congress enacted a series of laws that were designed to shift some of the costs of the Medicare program to private insurance companies. This series of legislation become known as the Medicare Secondary Payer program. What we have found out so far is that the implementation of the MSP program, at least in part, has failed—a failure that has cost the taxpayers billions of dollars over the past 10 years.

Yesterday we heard testimony describing the problems of MSP compliance in the insurance industry. Today we will hear from the other entities responsible for implementation of the MSP program.

We are very pleased to have as our first witness Gail Wilensky, the Administrator of the Health Care Financing Administration. She will discuss the role of HCFA in overseeing the MSP program.

Then we will hear first-hand from a Medicare contractor, Blue Cross/Blue Shield of Maryland, which administers Medicare benefits for hospitals in Maryland and Washington, DC.

And finally, we will hear from Constance Clark, Director of Patient Accounts at Johns Hopkins Hospital in Baltimore, Maryland. Ms. Clark will discuss the role of the hospitals in the MSP process.

I think it is perfectly clear that the responsibility for the success or failure of the MSP program rests with each of the entities or organizations involved in the process. It is not just that some insurance companies are shirking responsibilities under MSP. Although HCFA has come a long way in terms of implementing MSP since the early Eighties, I might say, among the many other programs of tremendous complexity that you have to administer, but it is clearly not doing enough since we continue to lose at least hundreds of millions of dollars per year on this one program.

I shall have some hard questions to ask. With respect to hospitals, I want to know why Johns Hopkins Hospital has repeatedly ignored audit reports showing noncompliance with MSP requirements and why HCFA has not done anything about it.

In short, we've got a lot of questions, and I hope we will hear some answers and particularly some solutions for the future.

As I mentioned, we are very pleased to have as our first witness Gail Wilensky, who is the Administrator of the Health Care Financing Administration.

I have to say to you, Ms. Wilensky, I think probably yours is one of the toughest jobs in Government, and I want to publicly state that I understand this is only one small part of your overall responsibilities; still, we have, according to GAO and others, substantial waste and fraud involved so that it is worthy of our attention.

Ms. Wilensky brings considerable expertise to HCFA, and we are looking forward to her testimony today.

I will say to our witnesses as I did yesterday, we have your full statements; each of them will be included in their entirety, so we would ask if possible for you to summarize your statements.

According to the rules of the Subcommittee, every witness is required to be sworn, so Ms. Wilensky, will you please rise and raise your right hand?

Do you swear the testimony you will give the Subcommittee will be the truth, the whole truth and nothing but the truth, so help you God?

Ms. WILENSKY. I do.

Senator ROTH. Please be seated. Again, we welcome you here, and please proceed.

TESTIMONY OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES [1]

Dr. WILENSKY. Mr. Chairman, I am pleased to have this opportunity to discuss the Health Care Financing Administration's activities regarding the Medicare Secondary Payer program.

Secretary Sullivan and I are committed to ensuring that the Medicare program does not pay for services for which private health insurers and other entities are liable. This is a goal that has been and will continue to be at the top of our agenda.

The Medicare program by law cannot pay for services in certain situations when there is alternative insurance coverage. In these cases, the other insurance pays first. Medicare pays secondary for any covered services not paid for by the primary plan.

HCFA has devoted significant effort and resources in the past several years to strengthen the enforcement of the Secondary Payer provisions and has achieved substantial savings for the Medicare program. In fiscal year 1990, our secondary payer activities resulted in approximately $2.2 billion in savings, and we expect to save a comparable amount in fiscal year 1990.

HCFA has three primary responsibilities in administering the Medicare Secondary Payer program: first, to establish regulations and issue policy and operational guidelines to implement the laws; second, to inform beneficiaries of their rights, and employers, insurers and providers of their responsibilities under the law; and third, to identify situations where Medicare is the secondary payer and process claims accordingly.

Let me summarize our activities in these areas.

In 1989, we updated our secondary payer regulations by publishing a comprehensive rule incorporating all Medicare Secondary Payer requirements, except those for disability. A proposed rule addressing the disabled was issued on March 8th and is now being prepared for publication in final form.

Over the last 3 years, we have pursued an extensive educational campaign. We have mailed educational material on the secondary payer program to all State insurance commissioners, to insurers, to employer groups and to over 500,000 physicians and their staff nationwide.

HCFA has developed a series of radio and television public services announcements which were widely broadcast. In addition, over 5,200 presentations were made before groups representing beneficiaries, providers, physicians, employers, insurers and third party administrators.

The contractors rely on beneficiaries and providers to identify and bill other primary payers of health care when Medicare is the secondary payer. However, this does not always occur.

Contractors use several methods to identify secondary payer situations and avoid mistaken Medicare payments. Contractors collect information about potential primary insurance coverage when they receive the first Medicare claim from an elderly beneficiary. If necessary information is not provided on the claim form, contractors

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[1] See p. 170 for Dr. Wilensky's prepared statement.

send a questionnaire to the beneficiary, asking about other insurance coverage, work status and spousal work status. This information becomes a part of the contractor control system to identify future secondary payer claims.

The contractors review all claims involving trauma which may have resulted from an automobile or work-related accident. They also compare current claims to past claims to identify possible alternative coverage. Some contractors review their private insurance records to determine whether a Medicare beneficiary is covered under an employer group health plan.

Contractors also conduct aggressive, systematic programs to recover mistaken payments when they identify that Medicare is a secondary payer subsequent to paying a claim. Recovery is sought either from the insurance company or the provider.

Contractors share their secondary payer information with other contractors through automated regional data systems. Early in 1991, contractors will be able to access a nationwide system of beneficiary utilization and entitlement data including secondary payer data.

We believe that these secondary payer activities serve as effective safeguards. However, we know that more needs to be done. Provisions enacted in OBRA 1989 will greatly strengthen our ability to identify beneficiaries who have health coverage through their working spouses' employer group health plan. We believe that these beneficiaries represent the largest category of undiscovered secondary payer claims.

The OBRA 1989 legislation requires a complex data match between the Internal Revenue Service, the Social Security Administration and HCFA. We are proceeding with a series of activities to implement the data match and expect to begin processing recovery actions by early 1991.

Our efforts to recovery mistaken Medicare payments are an important part of the Secondary Payer program. Medicare contractors attempt to recover mistaken Medicare payments as soon as they are identified. If unsuccessful, the contractor refers the case to HCFA. If we find evidence of intentional noncompliance with the secondary payer provisions, we refer the case to the Department's Office of General Counsel. In coordination with the Inspector General, our General Counsel will review the case for legal sufficiency and refer it to the Department of Justice. Justice files suit if it believes legal action is warranted. Justice has filed lawsuits against three insurance companies for violations of secondary payer provisions.

In a lawsuit against Blue Cross/Blue Shield of Michigan, the court ruled that the Government has a statutory right to recover Medicare payments made for beneficiaries covered under employer group health plans insured by Blue Cross/Blue Shield. The court also ruled that this right does not extend to situations where Blue Cross is acting merely as the administrator or payment processor for a self-insured employer group health plan. The opinion of the judge was that the self-insured plan, and not the entity who processes the claims, would be responsible.

In the suit against Provident Life and Accident, the court also ruled in the Government's favor to permit collection of improper

payments except when Provident was acting solely as an administrator. The court ordered Provident to provide HCFA with a list of employer group health insurance plans and beneficiaries subject to the secondary payer provision.

The Department of Justice has also filed suit against Travelers Insurance Company. A decision has not yet been reached in this case.

We will continue to examine the potential for additional cases against other insurers and responsible entities.

In addition to these three "offensive" cases, we are also the defendant in separate suits filed by the Health Insurance Association of America and the Blue Cross/Blue Shield Association. These suits challenge longstanding secondary payer policies that were incorporated into our comprehensive regulation. The Government believes it will prevail on the merits of the issues.

We believe we have an effective secondary payer program, as the $2.2 billion savings demonstrate. But we are not satisfied. We intend to be aggressive in our data match authority to improve our secondary payer performance. We will also continue to investigate alternative methods to improve the identification of possible secondary payer situations.

I appreciate your comments about the difficulties of being HCFA Administrator and the role that this plays, but I want to assure you that although we believe that the secondary payer problems represent a relatively small part of the expenditures on Medicare, it is nonetheless one that we intend to pursue with vigor.

I would be glad to answer any questions that you may have.

Senator ROTH. Thank you, Ms. Wilensky.

Let me ask you this question. What is HCFA's estimate of the amount the Government is currently paying unnecessarily in these MSP claims?

Dr. WILENSKY. There is some softness in our estimates. We think that the amount ranges somewhere between $400 million and $900 million. I apologize for such a wide range, but the problem is that we have difficulty in identifying the amount as well as sometimes recovering it, and therefore we vary in terms of our identification of how much is at risk. We believe it is under $1 billion and may be as low as half a billion dollars.

Senator ROTH. But either figure is a significant amount.

Dr. WILENSKY. Correct.

Senator ROTH. Now, I think sometimes when we zero in to these kinds of problems, we overlook the magnitude of the program. It sounds very simple when you talk about what an individual is required to do, but how many working aged are there?

Dr. WILENSKY. There are about 2 million working aged out of our 33 million beneficiaries.

Senator ROTH. So from the point of view of management, this is a huge program. How many claims do you figure you have a year from the working aged?

Dr. WILENSKY. Well, let me explain it is not only the working aged that are a problem. In fact, we think we are well on our way, with the provisions of OBRA 89, to resolving that problem. The even more difficult problem is when you have a spouse covered by the insurance of a non-Medicare beneficiary who provides coverage

to the Medicare beneficiary. That is another group, and it is the most difficult group to identify because the individual himself is not working.

Senator ROTH. You have the working spouse him or herself——

Dr. WILENSKY. Right, covering the Medicare person—well, we have the working beneficiary. That is one group where we are the secondary payer.

Senator ROTH. And then you have their spouses.

Dr. WILENSKY. And then we have a working spouse covering the Medicare beneficiary. So that the Medicare beneficiary is not him or herself working, but is covered by a working spouse, and that also——

Senator ROTH. Is to be treated the same as the working person.

Dr. WILENSKY. That is to be treated the same. And that is the most difficult of all for us to identify.

Senator ROTH. Then in addition to that of course you have those who have other kinds of coverage, whether it is from accident or liability insurance——

Dr. WILENSKY. Right; or from end-stage renal disease. Correct.

Senator ROTH. Let me ask you this question, and maybe it is naive, but why wouldn't it make sense—the process that has been set up now is that you essentially depend upon the beneficiary or the claimant; then you have certain checks. Isn't that the purpose of the matching that you mentioned?

Dr. WILENSKY. Right.

Senator ROTH. So that is sort of after the fact. Why wouldn't it make sense to try to create some kind of a data bank as to who are working and have such insurance? In other words, your employers are required under Social Security or other programs to file regular statements. They are the ones that know who has health insurance coverage. Why wouldn't it make sense to require them on some kind of a regular basis to supply, as part of their information, who are the working aged and have health insurance plans? This information could be kept in your regional data so that you could check that. Does that make sense, or could it be done that way?

Dr. WILENSKY. Well, it is not just the beneficiary who provides us with information. But in a sense, that is true. At the time that a Medicare beneficiary first files a claim with Medicare, a form is sent to the beneficiary, asking for information about whether or not they are working, whether or not they have other insurance coverage, whether or not the spouse has insurance coverage, even though the particular claim may not be involved with Medicare as a secondary payer, and that information is indeed put into a regional data bank that is available not only to the person's carrier but to other carriers.

Senator ROTH. But what I am saying is why not maintain a data bank, possibly on a regional basis, requiring the employer or possibly the insurance company that provides the coverage to provide the information? Under this scenario, you have that information in a data bank, and when the contractor goes to pay a claim, they first check the data bank.

Dr. WILENSKY. We have no objection to such a system. There has been some concern as to whether that places an undue burden, but we have no objection to that system. The issue that gets raised is if

such information does not get provided through our reporting system, do we stop processing claims until we have that information? But we have no objection; we think that is a reasonable way.

Senator ROTH. Of course, it seems to me the real political problem is that both the Government and the provider are under an obligation to provide care, and of course they want prompt payment, and that is understandable, and they are entitled to that. But it seems to me that part of the problem is because of the magnitude of the problem, that when you rely on the beneficiaries, many of them, to be candid, I suspect don't really understand what their insurance coverage is. Would you agree with that?

Dr. WILENSKY. Well, evidence has shown that they do not understand the details of their insurance coverage, but most people know whether or not they are insured, and I believe they would probably know whether they are insured by both their employer and Medicare. They certainly wouldn't know who is responsible for what part.

Senator ROTH. Is there a conflict of interest problem with private insurance companies processing Medicare claims as Medicare contractors?

Dr. WILENSKY. This issue has been raised on a number of occasions. You have at least a potential or a perception of a conflict of interest when the group that is processing the claim is an insurance company, and to the extent that Medicare pays more, they may be liable for paying less. So you certainly have such a potential.

The fact of the matter is by statute the only group who can be our contractors are insurance companies, although we are in the process now, at my request, of reviewing our whole contractor process, how we go about paying bills and doing medical audits. We may well be coming back, seeking legislative authority to expand the universe of who can serve as our contractor.

So we are aware of the concern for a potential conflict of interest. We believe that there are a series of steps in place to make sure that the contractors are carrying out their duties in a reasonable way. They are judged on the basis of how well they perform. Part of their performance evaluation depends on their Medicare secondary payer program, and they have goals for savings. So we have, we think, reasonable ways to try to make sure that there is not a real conflict of interest in action. But as I said, at the moment there is not a whole lot we could do about it anyway.

Senator ROTH. Primarily because there is nobody else who can do it?

Dr. WILENSKY. Right.

Senator ROTH. But at least theoretically——

Dr. WILENSKY. It theoretically sets up a problem.

Senator ROTH. It does place them in an advantageous position—or could.

Dr. WILENSKY. We think that in general their behavior has been all right. We think that there has been a disappointing lack of willingness to provide their data files to do a match with Medicare which would make identification easier, and that legislation blocked us from requiring a match. So we think that that was unfortunate. And that certainly suggests at least some potential for

conflict of interest in their minds if we were to get too sophisticated about how well we could go look at their files relative to our files.

Senator ROTH. Now, are Medicare contractors able to determine if they should pay primary or secondary from hospital admission form information? The Inspector General says a question should be asked whether or not the beneficiary or spouse has employer group health insurance. Do you agree?

Dr. WILENSKY. Yes, I agree with that. The question that is a little more difficult is what do we do in terms of processing payments if some of that information is not provided, especially in the beginning.

We think it is reasonable to ask the question. Our expectation is if we were to put that on the claims form as a requirement, it would take some time to educate the institutions that they really need to fill this out.

Our providers of health care get mighty displeased if we keep sending back their forms because they haven't put on something that they regard as extraneous to the immediate bill-paying process.

So, while we think it is a reasonable idea, we would probably be a little reluctant to withhold payment early on in that process if they did not complete the form, but would try to go through an educational activity to get them to comply.

Senator ROTH. I'd like to go back again to the point I made, because it seems to me that the problem with the current program is that you are essentially depending on the beneficiary each time.

Dr. WILENSKY. Well, you have given us a very powerful tool in OBRA 1989 through the data match. I believe that when we are able to complete the match between Social Security records, IRS records, and the contractor records for Medicare; identify through the IRS/SSA match individuals who are working or, more importantly, who have working spouses who have filed a W–2; go back to the employer; and seek information from the employer and then decide whether we have a recoverable action; that that will give us by far the best means of collecting on working spouses.

Senator ROTH. Let me see if I understand what you are saying and express what my concern is. Initially, a determination is, even under the current program, pretty much dependent on what the claimant tells the provider, whether it is the hospital or the doctor. As far as this matching is concerned, that is sort of a matter after the fact, although it will help you develop information to check. But in fact all that matching does is alert you as to who is working; then, case by case, you have to go back to the employer and ask whether an employer group health plan covers the beneficiary.

Dr. WILENSKY. That is true for the first round, but once we have information available that there is a primary payer, it will be part of the regional data bank. As of early 1991 when we have our common working file available so that the information is relatively easy to access across the country by all the carriers, that piece of information will not only be available after the fact, but will alert that this is a case where Medicare is a secondary payer and ought to be accessed before payment as well as after payment.

Senator ROTH. I understand, and I don't disagree with what you are saying, but I guess the main thrust of my question again is wouldn't it be better to go directly to the employer or possibly the insurance company and get the specific information on a regular basis as to who——

Dr. WILENSKY. Yes, yes, it would be.

Senator ROTH. Would that require a change in legislation?

Dr. WILENSKY. Yes.

Senator ROTH. Why don't we recommend that?

Dr. WILENSKY. We have been exploring this for future requests as part of our 1992 legislative package.

Senator ROTH. You are going to ask for that?

Dr. WILENSKY. Right.

Senator ROTH. Well, it does seem to me that——

Dr. WILENSKY. If not, something that would include that; I mean, if not that specifically, a variant on it.

Senator ROTH. Well, I am puzzled why—and I am not addressing you personally on this—as to why this was not done earlier, because it seems to me it is pretty obvious the best thing is to go to the best source of information you have.

Dr. WILENSKY. I think there has been some concern about the burden that this might put on the employer and insurance companies is my best response to that. We believe it is the most direct way, and we will try to pursue it. We do believe that we probably can do reasonably well, although with a lot more work, through the various data matching systems. If the private insurance companies would on their own, or if we had the legislative authority to require them to do a match against the Medicare records, that would provide substantial information, but we think this is also another way to do it.

Senator ROTH. Well, we can call this like we do in taxes, "tax simplification", as we add to the burden.

Dr. WILENSKY. Yes.

Senator ROTH. Frankly, I question whether in the long term it might not be simpler for either the insurance company or employer than the complex process we have now.

Dr. WILENSKY. There is nothing simple about the data match that is being proposed.

Senator ROTH. No, there certainly isn't, which I understand was imposed by legislation.

Dr. WILENSKY. Yes.

Senator ROTH. I want to make it very clear that I think much of the problem lies here in Congress; I think by the fact that we constantly change the laws and add to them makes your job very difficult.

In practice it does not appear HCFA has been completely successful in collecting accurate MSP information from providers. To what do you attribute it? Is it unrealistic to expect to obtain this information from the providers?

Dr. WILENSKY. I think that we do well in the inpatient setting. The studies that we have done indicate that information in the hospitals for their inpatient records are done well, that the accuracy is at a high level, and that it is functioning in an appropriate way.

Studies that have been done indicate that our compliance and the correctness with which our forms are filled out in the outpatient setting is substantially less and that this is a problem. I believe it is not particularly a Medicare Secondary Payer problem, however. The recordkeeping systems in outpatient departments of hospitals are notoriously inferior to those in inpatient departments. They are frequently not on an automated electronic basis, which introduces a lot of error and a lot of difficulty in coordination.

We are working with hospitals to try to improve that, and in particular our carrier has been working with Johns Hopkins, where there has been concern about their outpatient system. I do think that until individual hospitals automate their outpatient record systems for the entire outpatient department of their hospital that we will probably continue to have problems.

This is occurring and has been occurring in the 1980s at a substantial rate, but it is much more a reflection of some wider problems—and that is not much of an excuse; it just means that until we correct the general problem of making sure that recordkeeping in the outpatient system is as good as it is in the inpatient system, we will probably have difficulty in this area as well.

Senator ROTH. Well, the lack of adequate information of course means it costs the Government; isn't that correct, normally?

Dr. WILENSKY. Among other things.

Senator ROTH. Why not be tougher and somehow make these hospitals comply with MSP requirements? Isn't it primarily the larger hospitals that have outpatient clinics?

Dr. WILENSKY. Yes.

Senator ROTH. Why hasn't HCFA been tougher in this area and suspended payment until the hospitals did something about it? You get the sense that the practice is, oh, well, we'll just go along as we are without being too concerned.

Dr. WILENSKY. I think there are probably two reasons—maybe three. The first is that our attention in HCFA in trying to reform the system has started in the inpatient hospital and moved out to both the outpatient setting and physician, and that has happened in large part because the hospital is where the largest amount of money is spent. So that is where we have turned our attention first. We see that in terms of financing reforms, such as prospective payment. We started there with the inpatient. We are now just starting with the physician payment reform, and in 1991 will be delivering a report to Congress on outpatient payment reform.

So I think that the focus on hospitals has held not only in the recordkeeping but in all areas because that is where the largest sums of money are.

The other issue that you get into is that it is difficult to require major systems changes on hospitals which are expensive. It is difficult to require them as a condition of participation in general if the changes are not directly related to the ability to provide high quality patient care. But it is particularly difficult to require major systems changes at the same time that we have been trying to pursue with great vigor reductions in overall spending.

So I don't want to say that it may have been the wisest course, but it is difficult to tell a hospital that unless they completely change their recordkeeping system on a very large outpatient clinic

basis, that we won't reimburse them for Medicare at the same time we are trying to ratchet down on their payments in general.

Senator ROTH. I understand that the Medicare intermediary for Maryland identified nearly $8 million in recoverable MSP claims following a GAO audit. However, the HCFA regional office allegedly denied the intermediary permission to reallocate personnel to recover these funds. If, as you stated, contractors conduct an aggressive program to recover mistaken payments, why did HCFA forego this opportunity to collect $8 million?

Dr. WILENSKY. What we are doing with regard to our expenditures—and this is true for Medicare Secondary Payer, it is true for our payment safeguard programs in general—is to make sure we are using our limited funds as wisely as we can.

We would like to make sure that we are recovering as best we can, but we are particularly trying to make sure we identify the areas for future recovery. In some cases where we do not have the funds to immediately pursue recovery, we need to make sure secondary payer situations are identified so that we can pursue them in the future. Identification at least makes sure that we have the legal basis for further pursuit.

Senator ROTH. Let me ask you this. I believe in the Blue Cross testimony, the claim is made that for every dollar spent to collect, you save something like $68.

Dr. WILENSKY. Thirty-one, I think, but a large number.

Senator ROTH. So a large number. Would it pay to put on more people then?

Dr. WILENSKY. Well, it is an area that we have been struggling with. We have a contractor budget that basically serves two purposes. It is used to pay claims, and it is used for payment safeguards, one component of which is the Medicare Secondary Payer program. It is not the only component, but one component of our payment safeguards is the Medicare Secondary Payer program.

Our first priority in general has been to make sure that we are paying claims on time, in part because we have a very narrow window during which we must pay claims, as a result of Congressional legislation and in part because it is of such strong interest.

Senator ROTH. You would hear from Congress very fast.

Dr. WILENSKY. Congress, the provider groups, beneficiaries, and probably almost anyone else who got their attention raised.

We are requesting additional funds for our future budget to try to make sure that we have an amount that we think will really allow us to pursue these opportunities. But even with a budget as big as HCFA's, we have been squeezed in the past couple of years, and so we are trying to make sure that we allocate our funds where they will pay off the most, which has been in Part A recovery and in identification for further follow-up in later years.

Senator ROTH. Why does HCFA require providers to send no-pay bills?

Dr. WILENSKY. I don't know the answer to that.

Senator ROTH. Well, it might be something worthwhile looking into.

Dr. WILENSKY. The answer, I have been told, is that it is for recordkeeping purposes so that HCFA can know how many times and

how much money is being sent out to other payers so that we can see the amounts that are at risk.

Senator ROTH. Commercial insurers have referred to situations where two or more insurance companies are providing medical coverage as coordination of benefits problems. They have common data bases to which they subscribe, and the insurance companies presumably regularly consult with one another concerning the proper way to handle these cases. Commercial insurers such as Provident, who testified here yesterday, complain that many MSP claims could be settled if there were better communication available with the Medicare intermediaries as there is among private insurers.

Is this a legitimate complaint?

Dr. WILENSKY. No. We do not regard that as a legitimate complaint. We think that there has been an enormous amount of communication particularly since the mid-1980s with regard to contacts to the insurance companies, to employer groups, to all physicians, explaining what the rules are and providing information. If they want, we will talk with them on a regular basis. We don't believe that confusion is a problem; it is reluctance to be the primary payer that is the problem.

Senator ROTH. Ms. Wilensky, I appreciate your being here today. Again, I would like to work with you on this question of trying to get the direct information. There may be problems that we don't see, but it seems to me that it would expedite and would provide a data base that would enable you to determine prior to payment in a majority of cases rather than after.

Frankly, I don't envy you your problems.

Dr. WILENSKY. There is no question that if we can identify before the fact and not pay, it will make our job easier than trying to recover after the fact. So we will be pleased to work with you.

Senator ROTH. Thank you, Ms. Wilensky. We appreciate your appearance here today.

Our next witness is Jill Jacoby, Manager of Medicare Secondary Payer and Provider Relations for Blue Cross and Blue Shield of Maryland.

Ms. Jacoby has first-hand knowledge of the problems faced by Medicare in implementing the MSP program. We look forward to your testimony today.

As I mentioned earlier, anyone who is going to participate must be sworn. Do you want to introduce, Ms. Jacoby, your two colleagues, and then we will swear you in?

Ms. JACOBY. Certainly. On my right is Susan Howell, who is the Supervisor of the Part A MSP program; on my left is Charles Best, an MSP Senior Investigator.

Senator ROTH. All right. Would you please rise and raise your right hand? Do you swear that the testimony you will give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. JACOBY. I do.

Ms. HOWELL. I do.

Mr. BEST. I do.

Senator ROTH. Ms. Jacoby, as I mentioned earlier, we have your statement and have had the opportunity to read it. We appreciate

that. It will be incorporated in its entirety, and we would ask you to summarize your statement.

TESTIMONY OF JILL JACOBY, MANAGER, MEDICARE SECONDARY PAYER UNIT, BLUE CROSS AND BLUE SHIELD OF MARYLAND,[1] ACCOMPANIED BY SUSAN HOWELL, SUPERVISOR, PART A MEDICARE SECONDARY PAYER UNIT, AND CHARLES BEST, SENIOR INVESTIGATOR

Ms. JACOBY. Thank you.

We appreciate the opportunity to discuss our role as a Medicare contractor and our activities related to the MSP program.

Blue Cross and Blue Shield of Maryland has been a Medicare Part A contractor for institutional providers and a Part B contractor for physicians and suppliers since 1966.

In 1989, HCFA ranked Blue Cross and Blue Shield of Maryland's Medicare operation the number 2 Part A contractor and the number one Part B contractor in the Nation.

As a Medicare contractor, we operate under very specific HCFA directives. HCFA audits various aspects of our operations anywhere from monthly to annually.

Our MSP program has achieved a high level of success in its 5 years of operation. During the first 8 months of the current fiscal year, we spent $475,000 to achieve over $32 million in savings, far in excess of the goals set by HCFA. For every dollar spent, we have saved the Medicare Trust Fund $68.

The achievement of these activities is accomplished by 2 basic activities—obtaining other payer information prior to payment of a claim and using that information to identify prior erroneous payments and recover those dollars.

The success of the Medicare Part A MSP program is largely dependent upon the hospital giving Medicare the appropriate payer information when a claim is submitted. HCFA mandates that hospital admitting clerks ask the patient a specific sequence of questions to determine whether Medicare is in fact the primary payer.

In general, we find that the inpatient admissions clerks tend to ask the majority of the questions HCFA requires on a fairly consistent basis. Many hospitals use automated inpatient admitting systems that include MSP questions that must be answered before the admission can be completed.

On the other hand, we find frequent problems with hospital outpatient registration procedures. Typically these procedures are decentralized and are dictated by the individual outpatient departments rather than by consistent hospital-wide procedure.

If the registration clerk in an outpatient area does not ask all of the mandated questions, the billing department will not have sufficient information to determine just who the primary payer is. As a result, the billing department may submit the claim to Medicare when they should be directing the bill to another primary payer.

Once we identify a particular claim for which Medicare is not the primary payer, we examine the claims history for that beneficiary, looking for prior claims that may have been paid erroneously.

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[1] See p. 183 for Ms. Jacoby's prepared statement.

If such erroneous payments are found, the caseworker attempts to recover the Medicare payment.

The process for recovering erroneous payments from hospitals is relatively simple. We notify them in writing of the true primary payer and give them 45 days to submit a claim to that payer before we retract our own payment.

Recovering a Part B payment is much more complicated, however. Current HCFA policy mandates that we send a series of three demand letters to the insurer, provider or beneficiary. If we receive no response, we forward the case to HCFA, who will attempt a recovery on our behalf.

Our ability to be aggressive in this area is very dependent on sufficient resources. Since 1989, our MSP unit has been inadequately funded for the recovery of erroneous payments. Our fiscal year 1989 budget request to HCFA included funding for five additional caseworkers; HCFA approved two. Budget cuts in fiscal year 1990 forced us to terminate those two caseworkers and five more. These cutbacks prevent us from being as aggressive as we should be in payment recovery and result in a significant loss of savings to the Medicare program.

We have been asked by the Subcommittee to address the findings of hospital audits in general and in particular Johns Hopkins Hospital. HCFA requires that we perform 10 hospital audits per year. The findings of the Hopkins audits, conducted in 1988 and 1990, are similar to the findings from other hospital audits.

In 1988, our MSP unit conducted initial and follow-up audits at Johns Hopkins Hospital. In our initial audit we found that in 96 percent of the inpatient admissions examined, all or most of the required MSP questions had been asked. However, on the outpatient side, we found no evidence that MSP questions had been asked. At the time, Hopkins had 260 outpatient sites throughout Maryland, utilizing various registration procedures.

Senator ROTH. If I may interrupt, you say you found no evidence that the MSP questions had been asked—absolutely no questions asked?

Ms. JACOBY. We can't say that the questions weren't asked. We found no documentation that they were asked in the case files, the hospital's financial records.

Senator ROTH. There was no written record.

Ms. JACOBY. Right.

Senator ROTH. All right. Please proceed.

Ms. JACOBY. After the first audit, we recommended that Hopkins train outpatient personnel in MSP requirements and require that all MSP questions be asked at the time of every admission and registration.

During the follow-up audit we found little improvement in the outpatient registration process.

On April 25th, 1990, we again audited Johns Hopkins Hospital. This audit showed virtually no change in inpatient or outpatient procedures.

Senator ROTH. That was 2 years later?

Ms. JACOBY. Yes.

Senator ROTH. Okay.

Ms. JACOBY. We also found that in some cases the patient was allowed to determine which payer was primary. Further, if a registration record did not contain sufficient information to determine the appropriate primary payer, it appeared that the billers defaulted to Medicare, using a condition code that indicates that the mandated questions had been asked, and Medicare was definitely the primary payer.

There are a number of ways to improve the Medicare program. I will mention just two. We recommend that the Social Security Administration require every new Medicare beneficiary to complete and submit an MSP questionnaire prior to issuance of a Medicare card. This would help eliminate the "pay and chase" situation we frequently find ourselves in. Contractors would have valid primary information before the first claim was filed, minimizing payment errors.

Also, we believe HCFA should assign a high priority to the recovery of erroneous payments and provide increased, consistent and predictable funding for the MSP program. At the current 68-to-1 savings ratio, MSP is one of the best bargains in the Medicare program.

In closing, the Blue Cross and Blue Shield of Maryland MSP unit has proven to be successful in safeguarding Medicare Trust Fund dollars. With some improvements and with increased consistent funding, it can be even more so.

I appreciate the opportunity to discuss these issues and will be happy to answer any questions.

Senator ROTH. Thank you very much, Ms. Jacoby.

I would like to first ask a series of questions of Mr. Best. It is my understanding, Mr. Best, that you made the actual audit at Hopkins.

Mr. BEST. Yes, sir, that's correct.

Senator ROTH. Mr. Best, could you explain how you determined that the MSP questions had not been asked at Johns Hopkins?

Mr. BEST. The hospital had no record on file that they had asked the MSP questions. Hospitals are required to have a copy of the MSP Admissions Development Sheet on file. When I reviewed the outpatient records, there were no copies of the Admissions Development Sheet.

Senator ROTH. Did you ask them for a copy?

Mr. BEST. I certainly did. I was informed that the outpatient clinics do not complete an Admissions Development Sheet for outpatients at Johns Hopkins Hospital.

Senator ROTH. So that means that the billing office has no information on which to base their decision as to whom to bill; is that correct?

Mr. BEST. That is correct.

Senator ROTH. How do you know that the billing office defaulted to Medicare in the absence of other information?

Mr. BEST. Because of the claims that we have received from Johns Hopkins Hospital. Most of the outpatient claims have a condition code of 09, stating that the patient and the patient's spouse are unemployed.

Senator ROTH. Did you see a sticker on a biller's computer terminal instructing the biller to default to Medicare?

Mr. BEST. Yes, sir, I did.

Senator ROTH. Now, explain what that means exactly.

Mr. BEST. I had an instance to go over to the terminal to check a record when I saw a 3½-by-2 inch post-it pad that said "All Medicare outpatient claims must have a condition code of 09".

Senator ROTH. Must have code 09. Now, what does code 09 mean, again?

Mr. BEST. Condition code 09, states that the patient and the patient's spouse are unemployed, therefore Medicare must be primary.

Senator ROTH. In other words, if you put an 09, it was the practice—was this the Blue Cross practice, or was it a Federal requirement?

Mr. BEST. An 09 code is a code that a hospital can use in submitting a claim to Medicare to prove that they have investigated to determine if Medicare is primary and thus they prove that Medicare is primary——

Senator ROTH. To make sure I understand what you are saying, in other words, there was a sticker on the computer terminal which instructed the biller for these outpatient cases to code them as 09.

Mr. BEST. I did see a sticker on the terminal that stated that all outpatient claims should have a condition code of 09. However, I would like to add that most of the outpatient claims that come from Hopkins are submitted by tape; they are not terminally billed.

Senator ROTH. All right. What does that mean?

Mr. BEST. That means that in some instances they find the need to key a claim via the terminal rather than have it billed by tape submission. Because of their volume, as with many other hospitals, they choose a vendor to submit their claims; they present charge documents to them, and they are put in a format that they can be billed to Medicare.

Senator ROTH. Now, again, as I understand what you are saying, the 09 code means that neither patient nor spouse is employed, and for that reason, the Medicare program is the primary payer?

Mr. BEST. That is correct.

Senator ROTH. Prior to the audit, did you notice any patterns in bills submitted by Johns Hopkins with respect to the 09 code?

Mr. BEST. Yes, sir. That is why we decided to audit Hopkins, one of the reasons why we decided to audit Hopkins.

Senator ROTH. And what was the pattern?

Mr. BEST. In December of 1989 we issued a bulletin stating that we would increase prepay development and that hospitals should use codes to prove that Medicare was primary since they were expected to determine that information at the time of registration. We found that in January, all of the outpatient claims coming in from Hopkins had a condition code of 09, meaning that Medicare was primary. We had reason to believe otherwise, and we decided to audit as a result of that.

Senator ROTH. What was the situation before January?

Mr. BEST. Prior to January, prepay development wasn't as high as it was in January, and we found that Hopkins did other things—they used the term "Med prime" in the message field to

indicate that Medicare was primary; or when the claim would suspend back to them we would get notes called "Physician Service Request" or telephone calls from the hospitals, questioning why the claims were developed or denied.

Mr. RINZEL. I think it would be helpful if you would explain what some of those terms mean, because it is a little confusing to the non-expert. Are you saying that after you sent out this notification of increased prepaid development——

Mr. BEST. The increased prepay development started in January.

Mr. RINZEL. What does that mean, "increased prepay development"?

Mr. BEST. The increased prepay development is a situation where Medicare has required or asked hospitals to use condition codes and occurrence codes to prove that Medicare is primary. Prior to January, the codes were in place, but we were not requiring that Hopkins——

Mr. RINZEL. You were not requiring them; did Hopkins use codes prior to January?

Mr. BEST. No. They did not use the condition code 09. Other codes were used, but not the codes described in the bulletin sent in December.

Mr. RINZEL. So after you sent out this bulletin requiring them to use codes, immediately after that, everything from Hopkins outpatients started coming in as an 09 code; is that correct?

Mr. BEST. That is correct.

Mr. RINZEL. And the 09 code meant both the patient and the spouse were unemployed, and therefore Medicare was primary under those circumstances; is that right?

Mr. BEST. That is correct.

Mr. RINZEL. Okay. Thank you.

Senator ROTH. Thank you, Mr. Best. We may have further questions, but let me go back to Ms. Jacoby, if I may.

We heard yesterday from the Inspector General of HHS who asserted that the MSP hospital forms did not ask whether the patient had health insurance through an employer. Would it be helpful to have such a question?

Ms. JACOBY. Yes, it would, but it can't be the only question. While the working aged is the biggest portion of the MSP program, we also have other provisions to worry about—disability, end-stage renal disease, VA benefits, black lung.

Senator ROTH. Let me go back to some questions I asked the prior witnesses, and you were sitting here. I made the suggestion that perhaps it would be desirable to have some kind of a regional data bank based on information received directly from the employer or possibly the insurer, stating who they covered that were the working aged group. Would that simplify the administration of the MSP program in your judgment?

Ms. JACOBY. Yes, I think it can as long as the information is entered into the data base in a timely fashion and accurately. The key to the situation is making sure you have adequate primary payer information up front before the first claim ever comes through the door. So yes, I think it has a potential of helping to solve our problems.

Senator ROTH. Let me go back. What would be the advantage to Hopkins of using this so-called 09 code for all of these outpatient claims?

Ms. JACOBY. The code says we asked the questions, Medicare is primary. We as an intermediary have an obligation that if we get a claim with that code, we believe that we must process it that way unless we have very strong evidence to the contrary.

Now, most times when we have some inkling that there is another primary payer due to our data base information or the Social Security Administration's data base information, we will not just pay on that 09; we will develop further.

But if we have no information suggesting another primary payer, we must take that 09 at face value and pay the claim.

Senator ROTH. And within what period of time you must pay a claim submitted with an 09 condition code?

Ms. JACOBY. I am sorry?

Senator ROTH. Is there some time period within which you must make payment under an 09 claim?

Ms. JACOBY. Yes. Part of the contractor performance evaluation program and part of, I guess it is legislated, the time frame within which we must pay a claim—if it is a clean claim—that means we don't have to go outside our own shop to get any other information—we must pay it by the 24th day.

Senator ROTH. By the 24th day. But again, what you are telling me is that as a general rule, Blue Cross of Maryland depends on the provider's information unless it has substantial information to the contrary. You are required by law in those cases to pay within 24 days.

Ms. JACOBY. Yes.

Senator ROTH. Was the April 1990 audit the first time that these problems showed up at Hopkins?

Ms. JACOBY. No. These problems, as I said in my statement, were first seen in our 1988 audit.

Senator ROTH. Following the 1988 audit, did Hopkins request any assistance from your office to bring their procedures into compliance with the MSP regulations?

Ms. JACOBY. If you don't mind, I'll let Ms. Howell answer that. She performed the first set of audits on Hopkins.

Senator ROTH. Ms. Howell?

Ms. HOWELL. Would you repeat the question?

Senator ROTH. Following the 1988 audit, did Hopkins request any assistance from your office to bring their procedures into compliance with the MSP regulations? If so, did Blue Cross and Blue Shield as the Medicare contractor provide such assistance?

Ms. HOWELL. Yes. We as a Medicare contractor trained Johns Hopkins Hospital in MSP procedures. I do not have the dates of those training sessions, but they were trained.

Senator ROTH. When you say "they were trained", who was trained?

Ms. HOWELL. The billing personnel and the admission personnel.

Senator ROTH. From Hopkins?

Ms. HOWELL. Yes.

Senator ROTH. How well-attended were those training sessions?

Ms. HOWELL. They were very large classes. They sent their registrars and their admission personnel. And we showed the MSP video. HCFA puts out an MSP video to train hospitals. At that time we showed them the video and explained MSP procedures to them in depth, and explained to them how to bill Medicare as secondary payer.

Senator ROTH. When your audits reveal examples of continuing noncompliance by providers with Medicare regulations, what is your normal procedure for handling such cases?

Ms. HOWELL. We will go in and do the initial audit. We will review all inpatient and outpatient samples for a particular period. We advise the hospital that we are coming in and auditing their records, and we give them the month we are auditing. We go in and we perform the audit. We make them aware of any problems we have found with billing, admission practices. We do a written report. We send the written report to HCFA. We allow the hospital 30 days to come in compliance with MSP. We go back in 30 days; we call it a follow-up audit. If at that time they have not complied—we have to go in three times. That hospital has 90 days to come in compliance with MSP regulations. At the end of 90 days, if there is no change in the hospital practices, we forward the case to HCFA for—I don't know what they do with them, but whatever they do, we send them to HCFA.

Senator ROTH. Was the Hopkins case referred that time?

Ms. HOWELL. No, it was not.

Senator ROTH. Why wasn't it referred to HCFA?

Ms. HOWELL. Hopkins said at the time that they were implementing a new computer system, and they were showing a willingness to work with us.

Senator ROTH. But yet we learned from Mr. Best in 1990 that the situation had not been corrected; is that correct?

Ms. HOWELL. That is correct.

Senator ROTH. But I gather from your testimony, Ms. Jacoby, this was not an isolated case; this was true of other hospitals.

Ms. JACOBY. That is true.

Senator ROTH. What does this show? Does this show that there was just a general lack of real concern with complying with the law? Basically, I understand that the hospitals are required to provide care and that they must be paid if they are going to continue functioning, so they are under a certain amount of pressure themselves. But having said that, how did this situation develop where there seemed to be a lackadaisical or no-care concern about complying with the law?

Ms. JACOBY. I don't want to try and speak for Hopkins, but obviously, we audited Hopkins three times over a period of 2 years, and there was no punitive action at the end of any of those audits. All our audit reports were forward to HCFA. They knew the situation as well as we did, and I think perhaps the hospital said, well, nothing happened the first time so maybe nothing will happen the second time.

Senator ROTH. It seems to have become characteristic of enforcement of the whole MSP program. I think that is what bothers me so much. Every agency that has any role seems to not place a high priority on strict compliance with the law.

How many hospital or health care providers fall under your jurisdiction as a Medicare intermediary?

Ms. JACOBY. Hospital providers—we have approximately 95 hospitals.

Senator ROTH. You have all the hospitals in Maryland and D.C., is that correct?

Ms. JACOBY. Correct.

Senator ROTH. And you say that this situation described at Hopkins was not atypical, but rather, typical of the general practice.

Ms. JACOBY. Correct.

Senator ROTH. How many claims do you process weekly?

Ms. JACOBY. Oh, dear—well, our operation processes 1.5 million Part A claims per year, but I really do not know what we do weekly.

Senator ROTH. Okay. Let me ask you this. We have heard many hospitals complain that the reimbursements they receive from Medicare are inadequate to cover their costs. If that is the case, why then are hospitals eager to submit their claims to you, the Medicare intermediary, instead of to a private insurance carrier when given the option?

Ms. JACOBY. Again I can only speculate, but I do know from a report published on a quarterly basis by the Maryland Hospital Association that, at least in Maryland, we are the fastest payer.

Senator ROTH. Say that again, please.

Ms. JACOBY. We are the fastest payer.

Senator ROTH. In other words, Medicare pays much faster than private claims?

Ms. JACOBY. Yes.

Senator ROTH. What resources are available to you as intermediary to determine whether claims should, in fact, be paid by Medicare?

Ms. JACOBY. We have two data bases, the Social Security Administration's data base and our own. We also utilize the regional data exchange, which is, as has been mentioned, an exchange of information gathered by intermediaries such as ourselves and shared with other intermediaries in the region.

In our own particular case, we utilize some information we get from the private side of our enterprise. Blue Cross Blue Shield sends us enrollment information when they sign Medicare beneficiaries up for a Blue Cross Blue Shield health plan so that we can add that to our data base.

We also receive from them on a voluntary basis a listing every quarter of all the claims that they have paid on behalf of Medicare beneficiaries, and we utilize that information, update our data base and see if we have made any erroneous payments.

Senator ROTH. Now, I understand the General Accounting Office examined some 3,000 case files in your office that needed post-paid development. What did they find?

Ms. JACOBY. They found that we have $8.8 million sitting in folders waiting to be recovered. They also found that we are inadequately funded to do so and that HCFA had assigned a very low priority to payment recovery.

Senator ROTH. Couldn't it be the lack of follow-through on such claims, as that $8.8 million, leads to this lackadaisical attitude about complying with the law and the regulations?

Ms. JACOBY. I don't think so because the hospitals really don't—if you are asking about the hospitals' willingness to comply, I don't think that has any effect on it because——

Senator ROTH. How about the insurance company?

Ms. JACOBY. Yes, it may.

Senator ROTH. Did you pursue payment of these claims?

Ms. JACOBY. In the $8.8 million?

Senator ROTH. Yes.

Ms. JACOBY. No, not yet.

Senator ROTH. So the claims are still sitting there.

Ms. JACOBY. Well, let me correct that. We are doing payment recovery efforts. That has never stopped. The problem has been that the $8.8 million is there because as I said in my testimony, we have never been fully funded to pursue them and to keep up with the amount of cases we are developing.

As the methods of gathering primary payer information improve, we identify more cases, and we are not able to keep up with that.

Senator ROTH. Why are hospitals required to keep resubmitting the same information on the same patients each time a claim is submitted? Isn't this unnecessarily burdensome for the hospitals?

Ms. JACOBY. It can be, but there is a problem if they don't ask the same questions. If an employment status changes, the only way they are going to know is if they ask the questions. Perhaps the questions can be shorted to "Has your employment status changed since the last time we saw you?" but some question needs to be asked.

Senator ROTH. But that is burdensome from the standpoint of the hospital?

Ms. JACOBY. Yes, especially considering the number of questions that are required.

Senator ROTH. Now, you alluded to the regional data exchange program in your statement, which allows you to share valid payer information with other Medicare contractors. It is my understanding that the program is to be eliminated. How useful has that data exchange been?

Ms. JACOBY. Not very, to be perfectly truthful. It is a very young program, and the specifications by which one submits the information have not been very tight. We have not gotten good employer names or insurer names on some of that information.

Now, it is going away, but not really; it is going to be in a different form. That information will be added to the common working file. And all of us as contractors have been mandated to clean up the regional data exchange information by October 1.

Senator ROTH. I understand there was a proposal to require all Medicare contractors to match claims against their own private insurance side to ensure that at least the Medicare contractor is not allowing Medicare to pay primary rather than is own private insurance side.

I understand this legislation was strongly opposed by Blue Cross and Blue Shield of Maryland on the grounds that it would make them less competitive. Are you familiar with this debate?

Ms. JACOBY. Yes, I am.

Senator ROTH. Why would requiring matching impose a competitive burden on the carriers who are Medicare contractors?

Ms. JACOBY. Carrying out this kind of data exchange takes programming, computer time; it is a major expense, and it should be done frequently if it is done at all.

The problem is, however, that that only takes care of a portion of the secondary payer problem. There are other primary payers who are not contractors. There are third party administrators, there are self-insured groups. So the data exchange just between contractors leaves a lot of holes, a lot of informational holes.

Senator ROTH. But wouldn't that matching help answer the problem of conflict of interest?

Ms. JACOBY. I suppose it would. But again, we don't have that agreement in place now; I mean, that legislation was not passed. But in our particular case we are, as I expressed earlier, receiving enrollment information from our private side and quarterly reports on paid claims that in my mind proves the lack of conflict of interest in our enterprise.

Senator ROTH. Well, could it be said that the opposition to this legislation indicates that Medicare is, in fact, paying a lot of claims that should be paid by private insurance companies, and the Government is losing a lot of money?

Ms. JACOBY. No, I don't agree with that.

Senator ROTH. Well, then, why would there be a competitive disadvantage?

Ms. JACOBY. Only because data exchanges are very expensive things to do; you don't do it once, you do it once a month, or you do it once every quarter. Computer time is expensive. Only contractors would have that added burden.

Senator ROTH. Some experts claim that there is an inherent conflict of interest in private insurance companies acting as Medicare contractors. Do you make any distinctions in the handling of claims owed by your private side as compared to claims owed by other commercial carriers, and if so, what are they?

Ms. JACOBY. We make none. Our Medicare contract requires that we treat our private side as we do any other commercial insurer, and we undergo annual audits by HCFA, making sure that we are in fact following that edict.

As a matter of fact, we just finished up our audit in April, and we were told by HCFA in their written report that our performance was above and beyond what regulation calls for.

Senator ROTH. Is it not true that the private side agrees to pay Medicare claims within 30 days, and in return you don't send them demand letters and don't report them to HCFA?

Ms. JACOBY. That was true up until about 3 weeks ago. Last year we convened a group of representatives from the Medicare division and the private side to address how best to clear up part of that $8.8 million in unrecovered Medicare payments. We worked as a team and devised some quicker methods of notifying them of what was in our cases so that we could get the money turned over quicker. As a matter of fact, by the end of this year we had recouped a quarter of a million dollars in erroneous payments from our private side through that method.

But what has occurred since then is we have lost staffing. We lost staffing October 1, and we no longer have people to devote to this process. So about 3 weeks ago we met and decided to convert back to the demand letter system. We are no longer doing anything jointly with the private side because we don't have the staff to do it.

Senator ROTH. But prior to that time, then, there was a difference.

Ms. JACOBY. Yes, there was because they were returning payment quicker through this method.

Senator ROTH. One of your main recommendations calls for hospitals to collect more information, give more training and centralize registration locations. How do you respond to hospitals' complaint that this is overly burdensome and adds significantly to their costs?

Ms. JACOBY. Until there is a better way of gathering the information, I do not have an answer for them. The information is required to protect Medicare Trust Fund dollars. Without it, we are lost; we can't make the appropriate payment decisions. I don't have a good answer for them.

Senator ROTH. Would the collection of information from the employer help?

Ms. JACOBY. Yes, it would.

Senator ROTH. Finally, Ms. Jacoby, I would like to ask you this. Provident Insurance Company complained yesterday that there was no communication between Medicare contractors and private insurance companies and no guidelines for private insurance companies from HCFA. What is your response to that allegation?

Ms. JACOBY. Again, I can only speak for the private insurers that we deal with. Part of our MSP outreach program is training other insurers in MSP regulation, and Mr. Best has in fact conducted at least two such training sessions that I can remember, one with an HMO and one with, as a matter of fact, our private side.

Senator ROTH. Those are all the questions I have at the present time. We may submit some additional ones. I want to thank each of you for being here today. We appreciate your cooperation.

Ms. JACOBY. Thank you.

Senator ROTH. At this time, I would like to call forward as our final witness Ms. Constance Clark, who is Director of Patient Accounts for Johns Hopkins Hospital System in Baltimore, Maryland.

In her position, Ms. Clark has direct knowledge of the MSP requirements imposed upon hospitals and how hospitals respond to these requirements.

We certainly appreciate your being here today, Ms. Clark, and we look forward to your testimony. I think you heard what I said to the other witnesses, so would you please stand and raise your right hand?

Do you swear the testimony you will give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. CLARK. I do.

Senator ROTH. Thank you.

Please be seated, and as I said, we will include your full statement as if read. If you could summarize it, we would appreciate it.

TESTIMONY OF CONSTANCE L. CLARK, DIRECTOR OF PATIENT ACCOUNTS, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD [1]

Ms. CLARK. As you stated, my name is Connie Clark, and I am the Director of Patient Accounting at the Johns Hopkins Hospital, and I am responsible for all the hospital's billing components.

On behalf of the hospital—and I have heard the rest of the people today say they are "happy and grateful"—I don't know how happy I am, but I am grateful to tell you that——

Senator ROTH. Well, you represent a very fine hospital.

Ms. CLARK [continuing]. We are grateful to share with you some of the burdensome problems we have talked about today for hospitals. I will try to be more brief, but I'd like to take a moment to just mention a few things about the Johns Hopkins Hospital.

We are a 1,000-bed inner city teaching facility, and we have annual gross Medicare revenues of approximately $92 million with net revenues of over $335 million. Our volumes are vast. We have 37,000 admissions a year and approximately 350,000 outpatient visits per year.

We have talked a lot today about inpatients and outpatients. For the record, inpatient is when the patient stays overnight. An average inpatient account may be $5,000, $6,000. An average outpatient account is $100 to $150, to put this into perspective.

Currently, we have over 50 different registration areas and four admitting offices in our four-block complex. We do this for the convenience for our patients. We strongly feel that the time the patients spend in the hospital should be with the doctor, not standing in registration lines, and we are challenged to make that happen.

Senator ROTH. May I ask a question there. You said 50.

Ms. CLARK. Yes.

Senator ROTH. That's not your so-called outpatient, though.

Ms. CLARK. We have—and I noticed that the numbers were not congruent from other testimony—the 200 number that I came up, I believe, is we have over 200 registrars total. We have over 100 different clinics. But those 100 clinics are in about 50 or more sites or places where people go to be registered.

Senator ROTH. Within this four blocks?

Ms. CLARK. Yes, sir.

In the past 18 months when this came more and more to light, we at Hopkins have taken great strides to improve the situation. We have as a hospital reorganized our entire data processing department, and our objectives with that are to produce clean bills and collect cash. But more importantly, we are vitally aware that we need to interface all patient care systems so the physicians can get test results quickly as well as getting the proper payer information.

We are implementing now a state-of-the-art billing system that costs approximately $2 million, and we have been working feverishly to put this into place.

That's about the hospital. If I could just take one moment and talk about the environment, managing health care receivables continues to be dynamic and challenging. There exists, if you think

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[1] See p. 199 for Ms. Clark's prepared statement.

about it, no other industry that must respond to as many externally controlled billing mandates simply to maintain a steady stream of cash to meet our operational needs.

Maybe people don't realize it, but cumulatively in one year, HCFA and Medicaid issued more than 200 billing and reimbursement procedural changes that affected Maryland hospitals. Today the Johns Hopkins Hospital spends well over $2 million—and that is additional to the $2 million computer system we purchased—just to comply with all of these changes in our environment. So the environment is complicated and costly.

Now I'd just like to take a moment to tell you about our patients because that is the other component. Our Medicare patients are often confused and agitated when they are asked all of these questions at every, single visit. And realize that at Hopkins, we have many patients who walk from clinic to clinic, the same week, the same day; every time they go to another clinic it usually means a new bill. The law requires the hospital to ask these questions every time the sick patient moves to a new registration site. This is burdensome and unreasonable for patients and inefficient for the hospital.

I'd like to move now to talk about our Medicare compliance. We were recently, as we all know, audited by our intermediary, Blue Cross of Maryland, for our compliance with the Medicare Secondary Payer program. We received back from them a report of eight recommendations, and I have listed those eight recommendations and what we have done about them.

The first one—and if you want me to go through those one-by-one, I can——

Senator ROTH. Please proceed.

Ms. CLARK. The admission department must obtain and document all information regarding employment status and insurance coverage for the patient and spouse.

Our response to that is—and again, our audit showed that on inpatients we did very well as far as having the documentation for Medicare secondary payer. What we are saying here is that our standard admission form and procedure includes this information. The condition of the patient at the time of the interview may impact just how much information we do acquire.

We employ over 15 financial counselors for inpatient alone. These employees go to the floor and collect information that the admitting clerks miss on the front end. And again, we came out with a pretty favorable report on our inpatient high-dollar claims.

Number 2, all questions regarding MSP must be asked for all Medicare patients for both inpatient and outpatient.

And I stress again our patient condition—why would a patient have to go from site to site, day by day, and answer the same questions? Nonetheless that is our procedure that is documented in-house, and that is what we try to comply with and feel indeed we do comply with.

Senator ROTH. Let me ask you a question there. You say they go from site to site, and they are asked the same questions. Isn't that a problem of internal administration of the hospital?

Ms. CLARK. Yes, it is. The problem, though, is how do you collect the data and information. Again, we are in a four-block complex. And

because our new computer system and network is not up yet—that is what we are doing now—to solve all of these issues, there is not a computer terminal at every, single site that can inquire patient information.

So that is what we are working on right now to resolve. In order to be in compliance and to bill Medicare, we require all the registrars to fill out the MSP form and send it to the billing office. That is the procedure. We are relying on the patients here to give us that information.

On inpatient we showed full documentation. For one month, out of approximately 650 inpatient Medicare patients, there were only 14 Medicare patients that said Medicare is not primary. That is only 14 out of 625 or 650—I don't remember the exact number—but one out of 50 patients told us that Medicare is not primary. And this is where we do have it clearly documented, and we were advised that we did have documentation in this area. So I just want to keep that ratio in mind. One out of 50 patients, that is all we are getting.

That's why we feel this is such a small problem, because there isn't that much out there. So unless the Medicare——

Senator ROTH. Do you think it is a small problem when HCFA testified that it is costing anywhere from $400 million to $1 billion for improper payments under MSP?

Ms. CLARK. I thought I heard her say that there was not a solid number. One of our recommendations is——

Senator ROTH. She did say there weren't solid numbers, but she did give that range.

Ms. CLARK. Yes, half a billion, that's what I thought I heard, too. Again, I am talking from the experience of where we did come out well on our audit.

Senator ROTH. But in a sense—you are saying that is not significant—isn't that part of the problem? Again and again, we hear testimony that people seem to think that, well, this is just a small problem, and we don't worry about it. But when you look at the size of the program nationally, you are talking big bucks.

Ms. CLARK. The question is where best to collect that data, I think.

Senator ROTH. Well, why don't you go ahead with your eight points. I think we got away from that.

Ms. CLARK. I am on number 3, then. When completing the admission form, negative responses should be indicated.

We agree with that, and we are again, after this recommendation, going back with training to ensure that. With 200 registrars, we do have turnover. We are an inner city hospital with inner city employees and inner city patients. And we are working toward doing more complete training.

Number 4, the hospital should not allow the patient to decide which insurance should be the primary payer.

We agree, but the question is when a patient comes up who has been through this several times, is alert and feisty enough or well enough to argue, they will just say, "Medicare is primary; I know that." That happens. I don't think that happens a lot. I think the industry standard is we all have that happen, and we handle it accordingly.

Senator ROTH. But you really have no knowledge as to how often.

Ms. CLARK. No, I really don't.

Senator ROTH. Please proceed.

Ms. CLARK. I do not believe it is often when we explain that this is a requirement, et cetera, et cetera.

Number 5 was centralize and, if possible, computerize the outpatient admission process.

Well, I have already talked about our action in that with purchasing a $2 million computer system which we are now feverishly implementing. The inpatient portion of this system, which will be an on-line screen data base, will be implemented this December. And I have every reason to believe we are right on target with that. Outpatient will be coming up after that.

The sixth recommendation was train outpatient clinics and ER registration personnel and billing personnel on MSP regulations.

Again, we have had Medicare in to help us with this. We are going to continue to handle our turnover. After this audit, we went out and hired professional trainers to help us with this because we certainly want to be in compliance and show that we are making every effort that we are required to do. Again, it is costly to do that.

Number 7 is update the MSP information on recurring admissions, ensuring that the employment insurance information has not changed.

Our procedures that are documented say that this is what is to be done, and we see evidence of this being done.

Number 8, discontinue submitting bills with a condition code 09 to receive primary payments unless this information has been verified.

Because of our volume, since this audit, we have taken that off of our tape. We are a tape biller due to our volume. That condition code was removed. We still send in our Medicare bills. We are leaving that field blank because we have no computerized way right now, electronically, to any other indicator.

Senator ROTH. Let me ask you this. You say you have discontinued using 09; is that correct?

Ms. CLARK. Yes, sir.

Senator ROTH. Then, you agree that there were practices before that were disclosed in audit that raised serious questions as to whether these were proper billings.

Ms. CLARK. I do not, and let me tell you why. If I could just take one minute to describe to you the electronic world——

Senator ROTH. We are not talking about electronic world now, are we—we are talking about the questions that were asked of the outpatients.

Ms. CLARK. Right. When the outpatient vouchers come in to us from the clinics, all of them, we send them to an outside company which keypunches all these documents, with all the attachments. From that process, a billing tape is produced, an electronic billing mechanism, where the electronic bills go right to Medicare. This avoids hiring four, five, six people, hand-typing them in the business office.

When these codes came out, we were under the impression that we had to fill all these fields. And in the industry when we are

talking about electronic bills, we have what we call the uniform bill or a subset. It has 96 fields on it, and even though it is called "uniform bill," it is probably an un-uniform bill because we have many payers who require different information filled in different fields.

In doing our billing to Medicare, the clinic has an option of when to use that and when not to—when to say is Medicare primary or is Medicare not primary. And we feel that we are in compliance with that. We feel that now that the code has been turned off, we are at a big disadvantage because if only one out of 50 patients is truly affected and this wouldn't be true, then all of our business today is going in to be reviewed, and that is not correct either.

Senator ROTH. Rather than interrupt, why don't you finish as quickly as you can your basic testimony, and then we'll get to the questions.

Ms. CLARK. Number 3, then, we talk about the MSP compliance history at the Johns Hopkins Hospital. What I mentioned is that with the onset of the MSP requirements we have spent already, with all of our tape programs and front end tape editing, over $50,000 in the interim period while we are waiting for any system to come up. Certainly, we did do the training sessions, and we have been trying to increase the number of registration sites on our interim electronic measures.

We also built an edit into our system which has to do with the 09 code in that anything that comes to us electronically or from the clinics as Medicare primary. Before any bill goes to Medicare, it is edited against our own data base to see if Medicare has given back any other information or if we have collected any other information from any other time that patient was in-house. So we have put that very extensive program in place as well.

Our recommendations concerning the Medicare Secondary Payer program. We feel that HCFA and the Government and the intermediaries need to do more to educate their Medicare patients. Medicare patients don't understand why we are making it difficult for them. Even in the 1990 Medicare booklet to patient, the first time MSP is mentioned is on page 23. Our patients do not understand why they are being asked these questions or are required to do that.

We suggest that advertising on television might help this as well, more outreach to the patient.

We also recommend what you have touched on here today, mandate the current data base information within Social Security or the intermediary. From our own observations, I can tell you that we pride ourselves at Johns Hopkins Hospital for having very low billing rejection rates from all payers. We work our volumes on exception. And in Medicare alone, we get back less than, with all of our volume, five single notifications a week that their data bases have shown anything other than what we had to begin with. A more up-to-date data base would be helpful.

Another issue with that is that sometimes when we get rejections from Medicare saying this is Medicare secondary, not primary, we call the patient and do further development. If the patient proves that he is primary, we go back to the intermediary to tell them, but yet again when the patient comes in tomorrow, there is no way

for them to update their file, and the claim will be rejected again even if it is correct. So those are some of the problems we have with the data bases that exist.

Our third point is to perform a national study to ascertain a more accurate estimate of what the savings really are. I go back to what our Medicare patients tell us as inpatients, where we have the documentation on hand, and only 14 out of 642 patients were affected by this and were not primary. That's a very low ratio. Either everyone is not telling us the truth, or the opportunity is not as great as people think, and I don't know what that answer is.

The fourth thing is examine the reasonableness of requiring these MSP questions on every visit. We are a big cancer facility, and I don't have to paint the picture for you of Medicare patients coming in for their therapies and their visits every day, to be harangued by again asking all these questions.

Senator ROTH. Yes, you have made that statement, and I am sympathetic to it, but let's try to summarize.

Ms. CLARK. Number 5 is revise the MSP questionnaire to avoid confusion for both our patients and registrars. After this audit we tried to find a way that we might be able to train our own people better so that the Medicare patient may understand the questions. I have submitted for you a copy of what we recommend. It is very similar to the one that is in the Medicare manual, but we feel it gets to the right answer quickly and more easily than is already in the requirements.

We had recommendations for hospitals, ourselves as well as other hospitals in the industry, that the job description for registrars, these people who are out there on the front lines, meeting the patients face-to-face needs to be reevaluated. Historically these have been entry-level positions, or you have nurses who are tending to patient care in a busy clinic setting, trying to do everything to get the patient in to see the doctor.

In conclusion, with all of the new technology and the impetus for hospitals and providers of health care to find more alternatives to costly inpatient stays, more and more patients are coming in as outpatients; the numbers are increasing, and they are getting sicker. These patients are older and sicker, as I mentioned, and whereas we realize the necessity of properly identifying payment coverages, we feel that there must be a balance between the burdensome regulatory requirements and procedures which are less intrusive to our patients.

I'd like to conclude with that.

Thank you.

Senator ROTH. I am going to ask Mr. Rinzel to begin the questioning.

Mr. RINZEL. Thank you.

Ms. Clark, you have emphasized the fact that your hospital has a low rejection rate on the bills that you send to Medicare. But isn't it true that the 09 bills which you have been sending in from your outpatients have not generally been rejected. They have been accepted. Isn't that correct?

Ms. CLARK. I heard in the testimony that the bills that come in go through the match of the data base anyway.

Mr. RINZEL. But in any event the 09s that we have been talking about on outpatients, which classify them as unemployed, have been accepted by the Medicare contractor.

Ms. CLARK. Yes.

Mr. RINZEL. So only if those are all correct does your rejection rate argument carry a lot of weight; wouldn't you agree?

Ms. CLARK. Yes.

Mr. RINZEL. But when they did the audit in January 1990 and checked 75 records, there was no information in your billing office to show that these people were actually unemployed, so you were guessing that they were unemployed, isn't that correct?

Ms. CLARK. No, sir, that is not correct. Let me tell you what we feel is correct.

Mr. RINZEL. Well, did you have any information in the billing office to indicate the employment status of these people?

Ms. CLARK. In the billing office, I did not, but in the hospital, we do.

Mr. RINZEL. But you send the bills out from the billing office, isn't that correct?

Ms. CLARK. Yes.

Mr. RINZEL. Well, then, how can you send out bills to Medicare based on information that you don't have in the billing office?

Ms. CLARK. Because we get the information from the clinics, where there are very active procedures in place. We are in compliance with sending the Medicare zero pay logs in. We can show that 50 patients in the month of April we did fully develop on outpatient. After this audit we found, by going back to the clinics, that many of these papers are being housed in the clinic jackets, in the medical records of the patients.

Another group have the information on on-line screen. Some of ours do.

Mr. RINZEL. Did you have a default code in your computer system—did you make 09 a default code? That is, when you didn't have information about the MSP status of a patient, did you make it a default code? Did the 09 become the code that was submitted?

Ms. CLARK. I would like to answer that by saying going back to when the registrar interviews the patient, the requirement is——

Mr. RINZEL. It seems to me that question can be answered yes or no. That is what you told us during the staff interviews, isn't it, that 09 was effectively a default code for you?

Ms. CLARK. It is a code that is in our computer for our tape bills, yes. I am telling you it is. But for that to be used on our tape billing, the registrars make a decision—is this a Medicare secondary pay—and then they use another Medicare code that does not default; it does not have anything in the condition code. That is where some of this confusion lies.

Mr. RINZEL. Yes, I am thoroughly confused now, because you told us during the staff interviews that 09 was being used as a default code; when you did not have information at the billing office and didn't know how to bill an item for somebody who was Medicare-eligible, you billed it as an 09.

Ms. CLARK. What we said at the staff interview was that when patients are identified by our registrars after their filling out the form—the people who do the billing are not the people who talk to

the patients—I think we all know that. We do rely on the information coming from the front end. And when they indicate to us whether or not it is a Medicare secondary payer, certainly there is no default because then we go in and develop it and bill it to the payer, and we have full-time people who do that.

If it comes to us, and they have said to us Medicare is primary, yes, then that code 09 is used because I have no capability on my old billing system to insert any other code, but Medicare is still primary.

Mr. RINZEL. And you agree that that was an improper practice because you have changed it.

Ms. CLARK. I do not agree it is improper. In fact——

Mr. RINZEL. Then why did you change it?

Ms. CLARK. Because there was a recommendation, and we certainly want to show that we are doing everything we can. If only one out of 50 patients—more than that—that means that all of our outpatients—and we have over 3,000 a month today—are going to Medicare with a blank field. And that is not correct either. That is hurting us more than it is helping us, and it is not the truth.

So we are deferring that because we certainly want to do everything we can to do the job.

The other thing I need to mention to you is that since that audit, we have taken this very seriously. We have gone to the highest level of administration, with the backing and support of central administration, and the people we are talking to show these forms do exist in the clinic records. The registrars——

Senator ROTH. I want to interrupt for a moment because I am going to have to recess for 5 minutes because I have to go vote in Banking Committee.

So the Subcommittee will be in recess subject to the call of the Chair, which will be in about 5 minutes.

[Short recess.]

Senator ROTH. The Subcommittee will be in order.

I don't want to extend the hearing too much longer. Let me make a couple of comments, Ms. Clark, because I am bothered by the conflict in testimony between what we hear from you and what we have heard from the auditors.

Now, I don't pretend that we are here today to try to finally resolve that, although everyone here is, of course, under oath. But it does disturb me as I listen to the testimony and see that there were 75 cases marked as 09, meaning the patient and spouse were unemployed, and according to the testimony of our auditors, they did not receive as part of the auditing any adequate information substantiating that.

The thing that bothers me is that, as you yourself indicated, there are only 14 out of so many cases, and this is not a very big problems. With that, I strongly disagree. I think that the question of MSP is a matter of great significance to the Federal Government, and what I am particularly interested in is ensuring that we begin to put in place processes that will ensure the appropriate party pays claims correctly.

I understand and I am sympathetic with some of the issues you have raised from the standpoint of the hospital—the need to simplify the process from the point of view of the claimant, the need to

spend time with the doctors rather than filling out forms. At the same time, I am deeply disturbed that there does not seem to have been a great concern as to proper MSP development by hospital personnel.

Let me ask you this question. You heard my questions earlier to other witnesses, and I think I know what you will say, but I will give you the opportunity to state it. Would it make sense from your experience for the patient's insurance information to be collected either from the employer or the insurance carrier and maintained in some kind of a regional or centralized data base? Would that simplify the problem in your judgment?

Ms. CLARK. Yes, I think it would. Again, if it were an updated data base, it would work. I think it is putting the responsibility where it should be and not with the patient when they wish to tell us information and when they don't.

Senator ROTH. The 1988 audit by the Medicare contractor revealed many of the same flaws that were discussed in the 1990 audit. In fact, the recommendation sheets from both audits are almost identical. Both call for an improvement of the outpatient administration process, and both suggest regularly updating the MSP information on recurring admissions to ensure that the employment insurance information has not changed.

Can you explain why these same recommendations appeared on both audits, why no steps were taken in between to correct the situation?

Ms. CLARK. We feel that we did put steps in place between the audits. I have the 1988 audit as well, and the page I am looking at, dated June 30, says—this is from Medicare to us, and I won't read the whole thing—"From the review and training sessions, the following enhancements were identified: one, the development of an MSP questionnaire"—this is on Medicare's letterhead to our billing office; this is what they said we did do—"two, the training of outpatient registrars in MSP to aid identifying; three, the implementation of edits in the CAS system to ensure MSP-related questions are being pursued during the admission interview; four, the efforts on behalf of the billing department to detect the possible MSP beneficiaries and to work closely," et cetera; "five, the thoroughness of the admission interview in the outpatient service area."

This is what they said they saw in 1988. Yes, they have recommendations. The first one of concern was the lack of procedures for no-pay bills, which fails to inform the intermediary of Medicare savings. We were cited for that, and since they were here last, we have written a computer program and are in full compliance with the Medicare zero-pay log. We do that just like every other hospital in Maryland, and we submit that monthly. So these are the things we have put in place.

The second thing they cited us on in 1988 is the lack of interest by the ER clinic to obtain information with regard to automobile accidents and so forth. That continues to be a challenge to us, to get out to our four emergency rooms and talk to people and ensure that they are asking those questions. And for that reason, since then, we built an edit, a very costly edit, in our computer system as it exists. This is in addition to the $2 million we are spending on our brand new system. We said we can't wait for that; we have got

to show that we are doing everything we can to do a good job and to do things right. We put an edit in our own system that said any patient that——

Senator ROTH. When did you do that?

Ms. CLARK. That was after the 1988 audit. This was all in response, and we have spent additional moneys, and again, the no-pay bill situation, we have certainly complied with that since then.

Another issue—and again, this is one that we got this time that we had last time—is the representation at the training centers, admission personnel in all of our clinics. Again, with registrars being nurses sometimes, that has been difficult for us, and that has been a challenge, and that is one reason now why we are going to hire professional trainers to do this job, to make sure we keep going. It will be on an ongoing basis. We certainly don't do it quarterly, and we'll do it more so, and that is costly as well.

So I feel that since 1988, we have done well—better.

Senator ROTH. Let me interrupt. In effect it seems to me what you are saying is that you are putting into place now a number of changes to comply with the requirements of the law, which in a sense, I guess, admits that your old system or current system was not adequate, for whatever reason. Would you disagree with that?

Ms. CLARK. Yes, sir. I would say that was our cost justification for spending $2 million.

Senator ROTH. So that in that sense there seems to be some agreement between yourselves and the auditors that the current system does not meet the requirements of MSP, for whatever reasons.

Ms. CLARK. Yes.

Senator ROTH. Otherwise you would not be spending $2 million; isn't that correct?

Ms. CLARK. Yes, sir, and again, the $2 million certainly is not for MSP compliance alone; it is for processing our patients from one data center to another.

Senator ROTH. Well, Ms. Clark, I don't intend to prolong this hearing. I think we have gone into it deeply enough. I think that what I have heard today as well as yesterday does give me cause that there has not been adequate pursuit of a process to ensure that the proper payer makes payment primary to Medicare.

I have to admit that I think much of the problem is the magnitude, the number of people affected by the MSP laws and the complexity of the rules. But I also think the system failures are a result of somewhat of a lackadaisical approach by hospitals and others whose approach seems to be that as long as we get paid we don't care too much who pays. As I say, I am very much encouraged by you saying that you are computerizing and taking measures.

We appreciate your being here today, as well as the other witnesses.

I do first of all want to say that the staff report on MSP will be included yesterday as part of the opening record,[1] and I think there are a number of other exhibits, Mr. Rinzel.

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[1] See p. 87.

Mr. RINZEL. Yes. Exhibits A through RR, I would request be introduced into the record, Mr. Chairman.[1] I would also request the record be kept open for a period of 10 days for submission of additional statements or information.

Senator ROTH. Thank you.

The Subcommittee is in recess subject to the call of the Chairman.

[Whereupon, at 12:08 p.m., the Subcommittee was adjourned.]

[1] See p. IV for a list of the exhibits.

APPENDIX

STAFF STATEMENT[1]

I. EXECUTIVE SUMMARY

Our investigation of the Medicare Secondary Payer ("MSP") program, uncovered failures at all levels of the health care process as it relates to MSP, including instances of waste, fraud and abuse. For purposes of this investigation, we defined the MSP related process to include the collection of patient information by the health care providers; the billing of the patient claim; the processing of the patient claim by Medicare contractors; and the handling of the MSP claim by private insurers.

The Medicare Secondary Payer Program involves primarily the working elderly, people who are over 65 but who are still employed and who are covered by private health insurance through their employers. The program was designed, as its name implies, to ensure that the employer group health plans by which such persons are covered, pay the primary cost of medical bills while Medicare pays secondary.

While the Medicare Secondary Payer provisions apply to a relatively small portion of the total number of Medicare eligible persons,[2] the money the federal taxpayer loses on the MSP

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[1]This statement was prepared by the Minority staff of the Permanent Subcommittee on Investigations.

[2]The General Accounting Office estimated in 1988 that approximately 1.5 million Medicare beneficiaries (about 5 percent) have other insurance that should pay primary to Medicare. Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, November 29, 1988).

program is staggering. The Office of the Inspector General for the Department of Health and Human Services estimated in 1989 that the federal government still loses between $400 million to $1 billion per year from unidentified MSP claims.[3] The Health Care Financing Administration estimates that MSP loses from $700 million to $1 billion per year, despite vigorous cost savings programs currently in place. The General Accounting Office believes that even today MSP may lose $1 billion per year.

The investigation turned up evidence of failures at every level of the MSP process which prevent the program from functioning properly. Some of the significant problems identified by the investigation include:

1) Medical care providers do not do an adequate job of collecting accurate information from patients to enable Medicare contractors to properly evaluate MSP claims;
2) Hospital billing procedures are not always consistent with information collected from the patient and hospitals may misuse Medicare condition codes and incorrectly submit claims for Medicare to pay as primary;
3) Medicare contractors do not aggressively pursue MSP claims and there are few incentives for Medicare contractors to correctly pay claims; and
4) Some insurance companies have avoided compliance with MSP requirements and continued their previous practice of paying benefits secondary to Medicare, long after the effective dates of the MSP statutes.

During the course of the investigation, we selected, for in-depth review, one health care provider (Johns Hopkins Hospital) one Medicare contractor (Blue Cross and Blue Shield of

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[3]More Complete Employer Group Health Plan Information Is Needed To Administer The Medicare Secondary Payer Program, A-09-89-00100, March 20, 1990.

Maryland) and one insurance company (Provident Life and Accident Insurance Company). We found that Johns Hopkins has significant problems with MSP compliance, including its failure to collect necessary MSP related information from patients, particularly outpatients. We also found that Blue Cross Blue Shield of Maryland, which was recently rated the number two contractor in the nation for its MSP work in Medicare Part A, has insufficient personnel to process already identified MSP claims worth $8.6 million in money owed to Medicare. Our study of Provident Life and Accident Insurance Company revealed a long-standing coordinated practice of evading primary payments on MSP covered claims.

The problems discovered in the course of the investigation, indicate that there may be a need for systemic changes in the way the MSP program is implemented. The most pressing need is for accurate information on which particular beneficiaries fall into MSP categories. The most direct solution may be to require either insurance companies or employers, depending on which maintains the beneficiary files, to report to the government those employees who have health coverage who fall into MSP categories.

II. THE LEGISLATIVE SCHEME

The statutory scheme comprising the Medicare Secondary Payer program ("MSP program") is codified at 28 U.S.C. § 1395y et seq. Although adopted in piecemeal fashion, Congress intended the MSP provisions to reduce federal spending on Medicare and to ensure the continued fiscal integrity of the Medicare program. This was to be accomplished primarily by shifting to employer health plans the responsibility for being the primary payer of the medical expenses of the "working aged."

The Omnibus Reconciliation Act of 1980 ("OBRA 80")[4] was the first of this series of legislation. This Act provided that Medicare payment may not be made when payment has been made or can reasonably expected to be made "...under an automobile or liability insurance policy or plan ...or under no fault insurance..." 42 U.S.C. S1395y(b)(1) (1983).

The Omnibus Budget Reconciliation Act of 1981 ("OBRA 81") further amended the Medicare Act by providing that payment by Medicare for certain End Stage Renal Disease expenses would be secondary to employer group health plans ("EGHP"). 42 U.S.C. S1395y(b) (2) (1983). This amendment became effective for medical care furnished on or after October 1, 1981.

Perhaps the most significant change was the enactment of the Tax Equity and Fiscal Responsibility Act ("TEFRA") in 1982. TEFRA, also referred to as the working aged legislation, made Medicare benefits secondary to benefits provided by an employer health insurance plan for employees aged 65 through 69 and their spouses aged 65 through 69. TEFRA went into effect in January 1983, and applied to employers with 20 or more employees.

The Deficit Reduction Act of 1984 ("DEFRA") refined TEFRA to remove two anomalies: 1) in order for the TEFRA rules to apply to an older spouse, the active employee had to be between the ages of 65-70; and 2) people who did not enroll in Medicare Part B when first eligible at age 65 were subject to certain penalties and restrictions. DEFRA also provided the government with an explicit statutory right of recovery for Medicare overpayments against certain third parties.

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") removed the age 70 limit on the Medicare secondary

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[4] OBRA 80, Public Law No. 96-499,S 953, 94 Stat. 2599 (1980).

status of actively employed workers and their spouses. This legislation essentially completed the cycle begun in 1981 whereby Congress shifted the primary responsibility for health care coverage from Medicare to employer plans with respect to actively employed workers age 65 and over and certain spouses. After COBRA, employer group health insurance had primary payer responsibility for all actively employed workers and their spouses, regardless of their age.

The implementation of the MSP program has been criticized by various executive agencies in the government as being particularly susceptible to waste, fraud and abuse. While the Medicare Secondary Payer provisions apply to a relatively small portion of the total number of Medicare eligible persons,[5] the money the federal taxpayer loses on the MSP program is staggering. The Office of the Inspector General for the Department of Health and Human Services estimated in 1989 that the federal government still loses between $400 million to $1 billion per year from unidentified MSP claims.[6] The Health Care Financing Administration estimates that MSP loses from $700 million to $1 billion per year, despite vigorous cost savings programs currently in place. The General Accounting Office believes that even today MSP may lose $1 billion per year. The Health Care Financing Administration ("HCFA")[7] has no clear idea of how much money the government has lost in the MSP program since 1981, when Congress first enacted OBRA to try to control

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[5]The General Accounting Office estimated in 1988 that approximately 1.5 million Medicare beneficiaries (about 5 percent) have other insurance that should pay primary to Medicare. Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, November 29, 1988).

[6]More Complete Employer Group Health Plan Information Is Needed To Administer The Medicare Secondary Payer Program, A-09-89-00100, March 20, 1990.

[7]HCFA is part of the Department of Health and Human Services.

Medicare expenditures and shift the costs of health benefits to the private sector.

III. HISTORIC INTEREST OF PSI IN HEALTH CARE RELATED INVESTIGATIONS

The Subcommittee has had a longstanding interest in waste, fraud and abuse in the health care arena. Some of the previous Subcommittee investigations related to health care are as follows:

A. Hearings before the Permanent Subcommittee on Investigations of the Committee on Government Operations, United States Senate, on Prepaid Health Plans, Part 1, March 13 and 14, 1975; Part 2, December 14 and 15, 1976;

B. Hearings before the Permanent Subcommittee on Investigations of the Committee on Government Operations, United States Senate, on Defense Department's CHAMPUS Program, Part 1, July 23 and 24; Part 2, July 25 and 26, 1974;

C. Hearings before the Permanent Subcommittee on Investigations of the Committee on Government Operations, United States Senate on Medicaid Management Information Systems (MMIS), September 29, 30, October 1, 1976;

D. Report made by the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, United States Senate, on Prepaid Health Plans and Health Maintenance Organizations, April 20, 1978, Report No. 95-749;

E. Hearings before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, United States Senate, on Fraud, Abuse, Waste and Mismanagement of Programs by the Department of Health, Education and Welfare, July 20, 1978;

F. Hearings before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, United States Senate, on Home Health Care Fraud and Abuse, March 13 and 14, 1981;

G. Hearing before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, United States Senate, on Fraud and Abuse in Employer Sponsored Health Benefit Plans, May 15, 1990.

H. Hearing before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, United States Senate, on Health Care Costs and Revenue Recovery Firms, June 20, 1990.

IV. HOW PSI CONDUCTED THE INVESTIGATION

This investigation grew out of a larger investigation conducted by the Subcommittee on the issue of rising health care costs in the United States. In the course of this investigation, we uncovered allegations concerning waste, fraud and abuse at several different levels in the process of providing health care benefits to Medicare eligible beneficiaries. For purposes of this investigation, we defined the MSP process to include the collection of information from the patient by the hospital; the billing of the patient claim; the processing of the patient claim by Medicare and the way in which insurance companies handle MSP claims.

First, it was alleged that some insurance companies were intentionally continuing to pay secondary benefits behind Medicare for active employees age 65 and older and their spouses, despite legislation prohibiting this practice. While some insurance companies went to great lengths to educate employees on MSP requirements and implement changes necessary to comply with the various legislative enactments, other insurance companies maintained the previous practice of paying benefits secondary to Medicare. Second, it was also alleged that Medicare contractors did not have adequate systems in place to pay claims secondary to employer group health plans in the early 1980's and that even today, contractors continue to pay claims as primary carrier when they should be paying as secondary.[8] Finally, it has been alleged that many hospitals do not bill patient claims in accordance with MSP requirements. In particular, some hospitals do not collect adequate insurance information from the patients to determine whether private health plans or Medicare should be billed as primary. Some hospitals allegedly purposely bill Medicare as primary when there may, in fact, be other insurance which is primary.

In conducting this investigation, the Subcommittee received the full cooperation of officials from the Office of Inspector General at the Department of Health and Human Services, HCFA and the General Accounting Office. Each of these offices has had experience with the MSP program and each was knowledgeable about the problems with MSP compliance. Staff also surveyed the offices of several state insurance commissioners to determine whether they had any experience with Medicare beneficiary problems.

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[8]Medicare contractors are private insurance companies that contract with the government to provide Medicare benefits to eligible beneficiaries.

The staff surveyed several hospitals, including Georgetown University Hospital, George Washington University Hospital and Johns Hopkins Hospital System to determine what procedures each institution had in place to ensure compliance with MSP requirements. We selected Johns Hopkins Hospital System ("Hopkins") for further study. The staff attended an audit which was performed by the Medicare contractor in Maryland. The audit indicated that Hopkins has significant problems with MSP compliance, discussed more fully below. PSI staff conducted further interviews with Hopkins' officials, which essentially confirmed that significant problems exist with respect to MSP compliance. Many of Hopkins' MSP compliance problems may be shared by other hospitals.

In the course of the investigation, the staff conducted in-depth interviews with the Medicare contractor in Maryland, Blue Cross Blue Shield of Maryland. The Medicare contractor in Maryland is responsible for administering Part A Medicare benefits to hospitals in Maryland and Washington, D.C.[9] For the most part, the investigation concentrated on problems with Medicare Part A. The Medicare contractor administers Medicare benefits according to extensive rules and regulations issued by CFA.

Staff then sought out several prominent insurance companies whose practices with respect to MSP were thought to typify the activities of the industry. After meeting with and receiving full cooperation from representatives of John Hancock Mutual Life Insurance Company, Aetna Life Insurance Company, the Prudential Life Insurance Company and Blue Cross Blue Shield of the National Capital Area, we selected Provident Life and Accident Insurance Company ("Provident") for in-depth study. Provident is headquartered in Chattanooga, Tennessee, and maintains field

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[9]Medicare Part A refers generally to those services rendered by hospitals that will be reimbursed by Medicare.

offices throughout the United States. Our survey of Provident included interviews of current and former employees, examination of various Provident documents, and numerous meetings with Provident's attorneys.[10]

Finally, the staff met with representatives of the Health Insurance Association of America (HIAA) and the American Hospital Association (AHA) to compare their respective positions on MSP.

IV. THE FINDINGS

Overview

We conclude that failures to comply with Medicare Secondary Payer requirements exist at every level of the health care delivery system. The investigation focused primarily on the largest group of beneficiaries for whom Medicare pays health benefits secondary to Employer Group Health Plans -- the working

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[10]While Provident cooperated with the Subcommittee in some respects, it used judicial process, unsuccessfully, to try to prevent a subpoenaed witness from testifying in a deposition before the Subcommittee. Provident attempted to obtain a Temporary Restraining Order (TRO) to prevent one of its employees, Marilyn Shelley, from testifying before the Subcommittee. The Federal District Court for the Eastern District of Tennessee denied Provident's motion for a TRO on June 11, 1990. The Subcommittee met twice in executive session to determine the status of a memorandum written by Provident employee, Marilyn Shelley, to another Provident employee, Dana Reynolds, in 1985. In the memorandum, Shelley asserted that Provident's claims instructions violated federal law. Provident claimed that the memorandum was subject to the attorney-client privilege. The Federal District Court for the Eastern District of Tennessee had ruled in an evidentiary hearing in a related case that the document was subject to the attorney client privilege. Chairman Nunn ruled that if the privilege had ever existed, Provident had waived it when it produced the memorandum in unredacted form to the Department of Justice during the course of litigation with the Department. Materials relating to this decision have been made a part of the hearing record.

aged and their spouses.[11] The term "working aged" refers to those beneficiaries who are active employees between the ages of 65 and older and their spouses regardless of age.

Hospital Admissions and Billing

When a patient first enters the hospital, the admissions office admits the patient after collecting certain information, including insurance information, from the patient. Indeed, it is often the case for non-emergency, scheduled procedures that hospital admitting personnel obtain this information from the patient on the telephone or through the mail. Most hospitals use standard admitting forms that provide spaces for insurance information and Medicare coverage. Some hospitals have computer systems for collecting this information rather than collecting it through the use of handwritten forms.

In an effort to ensure that necessary MSP information was collected during the hospital admissions process, in 1983 HCFA developed an MSP questionnaire for hospital admissions personnel to fill out and submit to the billing office along with the admitting form. HCFA requires hospitals to keep the information contained in the questionnaire in the patient's file for audit purposes to ensure that information regarding primary coverage

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[11] Medicare pays secondary health benefits when the beneficiary has health benefits from one of the following categories:
A. Black lung;
B. Worker's compensation;
C. End Stage Renal Disease during the first year of entitlement;
D. Active employees over age 65 with employer coverage and spouses of any age;
E. Auto liability;
F. Disability, which applies to individuals under age 65 who are covered by large group health plans (LGHPs);
G. Medicare eligible individuals who have Veterans' Administration coverage.

has been developed.[12] While most hospitals obtain the information required by the form, some do not.

A significant problem at the initial stage of the MSP process occurs when hospitals do not collect accurate and complete information from the patient. Hospital admitting personnel tend to be entry level employees with limited training. There is also a high level of turnover among these employees, which makes it difficult for the hospital to retain qualified, trained workers. Further, hospitals are in a competitive service business and admitting personnel are much like public relations people for the hospital. They are, therefore, not inclined to press patients for the required MSP information. Moreover, determining whether a Medicare eligible patient has insurance through his or her employer or whether his or her spouse has such coverage can be confusing both for an elderly patient and for an inexperienced admitting clerk.

Nevertheless, the need for accurate collection of information at the front end of the MSP process is clear. It is also clear that most hospitals do a much better job of obtaining insurance information from inpatients than from outpatients. One reason for this disparity may be that inpatient bills tend to be much higher than outpatient bills and the hospital is more at risk financially if there is a mistake made on inpatient bills. Also, since an inpatient stays in the hospital longer than an outpatient there are more opportunities for hospitals to follow up on gathering information with inpatients.

According to some hospitals, some patients simply present their Medicare card at the time of admissions. The patients may not be aware that they have other applicable insurance unless asked by the admitting clerk. Also, many admissions personnel

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[12]Hospital Intermediary Manual, § 301 (February, 1987).

ask the patient which insurance is primary, rather than simply collecting the underlying information and providing it to the billing office. Such practices do not result in accurately identifying MSP situations because many patients may not know in what circumstances Medicare is primary or secondary. Indeed, elderly patients sometimes insist that Medicare pay for their costs even when they have other primary insurance. Apparently these patients feel that since they have worked for many years and paid into the system, it is now their right to get something in return and they are entitled to have Medicare pay their bill. Hospitals also report that some elderly patients refuse to provide information about insurance coverage they have through employers to avoid filing a claim with their employers for fear that doing so may affect their job status.

Another significant problem in the MSP process occurs in the hospital billing office. The purpose of collecting the MSP information upon admission is to ensure that hospitals have obtained information regarding primary insurance other than Medicare. However, the admitting office and the billing office of a hospital may have little communication with one another and may be located in separate physical structures and be supervised by different departments of the hospital. Some admitting offices have some quality control checks in place with on-site supervisors performing audits of patient admissions. Other hospitals have no way of ensuring that the admissions offices are employing procedures sufficient to comply with MSP--in short, no quality control or internal review at all.

The hospital billing office is responsible for submitting patient claims to the proper party for payment. Generally, the hospitals submit computerized batches of Medicare claims to the Medicare contractor for payment. In order to simplify recordkeeping and expedite payment of claims, HCFA has specified occurrence codes and condition codes to be used by the hospital's billing office and the Medicare contractor. Condition codes

describe the status of the patient. Occurrence codes provide dates that may define MSP situations. These codes represent a means of shorthand communication between the hospital and the Medicare contractor. The codes determine how the contractor pays the claim. By using certain codes, the billing office of a hospital can ensure that Medicare handles the claim according to certain routine procedures used by Medicare. Misuse of HCFA codes and inaccurate collection of information by the hospitals obviously create significant problems for the Medicare contractor, whose job it is to pay health claims on behalf of Medicare when Medicare is the responsible payer.

In an effort to assist hospitals with billing MSP claims, one Medicare contractor, Blue Cross Blue Shield of Maryland, issued a bulletin in December 1989 reminding hospitals in its service area of the available condition and billing codes. These codes have been in existence since 1983. According to Blue Cross, after this bulletin was issued, one hospital, Johns Hopkins, began to submit most, if not all, outpatient claims using an "09" condition code. As previously stated, condition codes describe the status of the patient. An "09" code means that the patient is unemployed and if there is a spouse,the spouse is also unemployed. In response to an "09" code, Medicare generally pays the claim automatically as primary. According to personnel in Johns Hopkins' billing office, the hospital designed its billing system to utilize "09" as a default or miscellaneous code. When the billing office could not determine what billing code to use in submitting a particular claim, this system was designed to automatically submit the claim to Medicare under an "09" code. Thus Johns Hopkins' billing office submitted claims to Medicare describing patients as unemployed regardless of whether the information regarding patient or spousal employment was collected. Johns Hopkins defended this practice based on expediency -- it did not want to delay processing of the bill to wait for patient information, which may not be forthcoming anyway

because the MSP information is not routinely developed for outpatient claims.

Hospitals need to do a better job of collecting accurate insurance information from patients, both inpatients and outpatients. Admitting personnel should collect the facts and should not determine the order of benefits, unless they have specific training on this subject. Patients should not be required to determine which insurance is primary and which is secondary. In most hospitals, there needs to be better communication between the admitting office and the billing office. Although the billing office does not want to delay processing claims, it should not submit claims without proper documentation from the admitting office. Finally, hospitals should not be permitted to design their data systems to utilize Medicare billing codes for purposes contrary to the Medicare regulations.

Claims Administration at Medicare

Medicare contractors are private insurance companies that contract with the government to administer health benefits provided by the government. HCFA is responsible for overseeing the Medicare contractors throughout the United States. HCFA has several regional offices that perform this function. With the enactment of the MSP legislation beginning in the early 1980's, HCFA was required to make significant revisions to the system of processing Medicare claims.

On the one hand, some have argued that there is an inherent conflict of interest in having a private insurance carrier administer a government program, particularly an entitlement

program like Medicare.[13] The perceived weakness in the system results from using private insurers, which administer their own private health benefit plans, to also administer Medicare benefits. The contractors are expected to review claims and identify potential MSP claims, which should be paid as primary by private insurance companies, who are sometimes the private side of the same contractor. The contractor may have incentive to not strictly adhere to the MSP requirements when doing so entails having its own company pay money that would otherwise be paid by Medicare. Although many insurance companies who act as contractors attempt to build some type of "Chinese wall" between their private and government operations, this may not always be effective. Our investigation indicated that Medicare contractors sometimes treat their company's private side with a deference not given to other third party commercial carriers.

On the other hand, the government achieves certain economies of scale using private insurance carriers to administer Medicare; HCFA has determined that it is more cost effective to contract with existing insurance companies than to undertake to administer Medicare itself. While the Medicare contractors do not reap significant profits as a result of their government contracts, they do have some of their overhead covered by the federal government.

Medicare is required to pay all claims within 60 days of receipt, and so-called "clean claims" within 17 days. Clean claims are those claims which contain complete information and require no further development before payment. Although Medicare reimburses providers at a lower rate than commercial carriers, the payment is in many cases more certain.

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[13]Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare, (GAO/HRD-89-19, November 29, 1988).

Medicare contractors use three data systems to help identify MSP claims. First, they use a data base from the Social Security Administration to identify beneficiaries that are working and therefore may have some type of health coverage. Second, there is a regional data base which accesses information of the files of other contractors in the region for comparison purposes. The Regional Data Exchange will be replaced in July 1990. In its place, contractors nationwide will submit a computer tape of MSP information to a cable system, which contains the Social Security data bases. Finally, there is an in-house system to maintain pertinent information on Medicare beneficiaries. These systems provide information that may lead to identification of an MSP situation. According to the contractors, however, the systems could be better utilized if they contained more relevant information on the beneficiaries such as name and address of employer, insurance plan number, effective and/or termination dates of employment and insurance information on the spouse. HCFA does not require that this information be provided to the contractor, and it is not done on a voluntary basis.

While Medicare contractors are critical of the lack of accurate data they receive from hospitals, hospitals are highly critical of the way the contractors maintain their data bases. For example, a beneficiary may be listed in the contractor's data base as employed, but more recent information provided by the hospital indicates that the beneficiary is retired. Medicare pays primary coverage for retired beneficiaries. The hospital may provide this updated information to the contractor, after the contractor has returned the claim to the hospital for further development. The contractor may then pay that particular claim as primary. However, the contractor does not update its data base with the new information unless the hospital submits an admission development sheet signed by the patient. The next time a claim comes in for this beneficiary, the hospital must go through the process again. This is a source of frustration for the hospitals because there is a delay in processing the claim

and they must go back to the patient and obtain signed statements. The contractors defend this practice of refusing to update their data bases based on information provided by the hospitals because, based on experience, they are not confident of the accuracy of such hospital provided information. According to the contractors, requiring a signed statement by the patient increases the likelihood of receiving accurate information.

The Medicare contractors are evaluated annually by HCFA based on whether savings goals or savings quotas established by HCFA have been achieved. These evaluations are part of the Contractors Performance Evaluation Program ("C-PEP") and are based on savings goals each contractor is expected to achieve. GAO has criticized the use of C-PEP evaluations because the goals are to too easy to achieve.[14] According to GAO, some contractors reach their savings goals in the first quarter of the fiscal year, then divert resources earmarked for MSP to other areas. There is little incentive to recoup anything above the established goal and the more a contractor exceeds its goal, the higher its savings goal will be for the next year. Also, it was reported that those contractors with the worst performance record still received 95 percent ratings on the C-PEP evaluations. Finally, it appears that there are no penalties imposed if the savings goals are not achieved.

The ineffectiveness of C-PEP scores is illustrated by a situation that occurred at Blue Cross/Blue Shield of Maryland, the Part A Medicare contractor for hospitals in Maryland and Washington, D.C. This contractor had approximately 3,000 files which required post-pay development. That is, the contractor had identified 3,000 beneficiary claims files in which Medicare had made erroneous payments as primary carrier when it should have paid as secondary. A GAO audit of these files revealed over $8

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[14]Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare. (GAO/HRD-89-19, November 29, 1988).

million in claims which were owed to the government. The contractor requested permission from HCFA to shift existing necessary personnel to develop these claims, yet HCFA refused to permit the contractor to allocate the personnel necessary to process the claims. Further, in the contractor's budget for FY 1991, HCFA did not include resources to process these claims, which represent guaranteed money to the government. HCFA maintained that the contractor should be processing these post-pay claims in the course of carrying out its normal duties. However, the contractor claims it does not have sufficient resources to process these claims in addition to performing its other duties. Whatever the merits of these countervailing claims, the fact that the contractor had identified but not collected over $8 million worth of outstanding claims owed to the government was not reflected in the C-PEP evaluation.

In addition to the potential conflict of interest that exists when a private insurance company administers a government program like Medicare, there is an inherent difficulty with the method in which Medicare operates that makes it less efficient at administering claims than a private insurance company. Medicare is an entitlement program, and as such, some of the techniques employed by commercial insurance companies to ensure proper payment have not been implemented by the Medicare contractors. Because of the need to ensure prompt payment on valid claims, Medicare contractors have not aggressively employed a procedure known as "pre-claim development," which would result in fewer errors in payment. Pre-claim development would entail holding a claim until Medicare was certain that payment was correct. Using this procedure, a claim for which there might be primary insurance would be held for 45 days, pending collection of further information. If, after 45 days, there has been no response from the hospital, the claim would be denied.

The Insurance Companies' Response to MSP

In an effort to reduce skyrocketing health care costs, many large employers have shifted away from buying straight or traditional health insurance for their employees and have become self-insurers. Today, most, if not all, fortune 500 companies are self-insured. When an employer insures itself, it assumes the risk of providing coverage itself, rather than paying premiums to an insurance company to assume that risk. Nevertheless, many self-insured employers contract with insurance companies to administer their health benefit plans. Under these arrangements, the insurance companies do not actually insure the employees. Insurance companies offer a wide variety of administrative services and insurance combinations to their customers.

When Congress enacted TEFRA in 1982, it became clear that the costs to insurance companies and self-insured employers of providing health benefits to the working aged population would increase, because Medicare was no longer the primary payer for the working aged. Indeed, the purpose of the law was to shift some of the costs of providing health benefits from the federal government to the private sector. Insurance companies responded to TEFRA by raising their premiums for employers which had working aged employees and spouses who would no longer have primary coverage through Medicare.

At the same time insurance companies were adjusting their premiums to cover the additional risk the law required them to assume, they were also confronted with the task of determining how to administer MSP claims. At least initially, HCFA did not provide much assistance. This created confusion, and more significantly, opportunities for abuse by some insurance companies.

Some insurance companies made significant efforts to understand the effect of TEFRA and educate their employees as to how the claims administration would change in response to the new legislation. Other insurance companies, such as Provident, quickly realized that HCFA had material weaknesses in its system of Medicare claims administration and was slow to respond to new legislative mandates. Provident took calculated risks, and even though Provident promptly imposed additional premiums on its customers in response to its new obligations under TEFRA, Provident capitalized on the perceived ineptitude of the Medicare contractors with apparent impunity and initially continued to pay MSP claims on a secondary, rather than primary, basis.

Provident did not educate its employees about the new changes in claims administration for MSP categories. In fact, Provident initially instructed its employees to continue to pay claims as they had prior to the enactment of TEFRA. Later, Provident adopted a policy of continuing to pay secondary in situations where Provident knew that Medicare had mistakenly paid primary.

A review of Provident internal documents revealed numerous examples of correspondence in which Provident acknowledged that TEFRA required Provident to pay primary to Medicare on claims of the working elderly and their covered spouses. See, e.g., Memorandum from Provident Executive T.J. Johnson, Jr. to Provident Executive P.J. Anzalone dated July 11, 1983, ("...we are legally obligated for primary benefits back to January 1, 1983, and the federal people can come after us for additional payments in cases where we paid secondary;..."); Letter from Provident Executive Charles Griffith to Donald Reardon, an associate regional manager, dated September 13, 1983, ("the law is very clear in that we have liability as primary carrier beginning January 1, 1983.").

While Provident professed confusion as to the effect of the adoption of TEFRA in late 1982, it wasted no time in determining how to raise premiums for its customers. Provident issued memoranda to its customers stating that effective January 1, 1983, rates would increase $55 or $75 per month for each person who was age 65-69 and each spouse.

Even though this rate increase was passed on to its customers effective January 1, 1983, during that same month Provident issued a bulletin to its claims adjusters notifying them as follows:

> "...some Medicare administrators will continue to pay claims incurred in 1983 on active employees ages 65 to 69 as primary for the first few months of 1983. Apparently they are not yet set up to handle secondary payment. If the administrator is continuing to pay as primary we should pay as secondary and be prepared to reimburse Medicare in the future if called upon to do so."[15]

In this same bulletin, Provident instructed its claims adjusters that "a log of these claims should be kept for ready reference."[16] Despite the requirement to maintain logs of claims where Provident improperly failed to pay as primary insurer, Provident has informed Subcommittee staff that no such logs exist, that no logs were ever kept on a systematic basis, and that if the logs did ever exist, they "...were kept for a short time and then discarded or destroyed in the ordinary course of business."[17]

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[15]Provident Group Claim Bulletin 83-1.

[16]Id.

[17]Affidavit of Timothy H. Bolden, Associate Counsel, Provident Life and Accident Insurance Company, dated July 5, 1990, Paragraphs 6 and 12.

As late as March 1985, Marilyn Shelley, Provident's Training and Communication Analyst for the Group Claim Department, stated in a memorandum that there was "time loss and aggravation in maintaining a manual log of these claims." Shelley also stated that in her opinion Provident's previous claims instructions create "a violation of federal law when we pay as secondary carrier."[18]

Provident's policy of assessing its customers a surcharge for the working aged and their spouses, yet not paying as primary carrier, was called into question and criticized by its customers. Upon review of their medical claims many customers apparently noticed that Medicare, not Provident, was paying the claim as primary insurer. According to one Provident senior salesman, "Many of our customers have complained they [sic] are/were being surcharged for a liability which we have not assumed yet. As a matter of fact, several brokers and customers have approached me for a refund of the surcharge."[19] Provident refused to refund the surcharges to its customers, however, saying that "[i]t may be years before we know how much of the offsets we have taken since January 1, will have to ultimately be paid to Medicare administrators and/or the Federal Government. As a result, we do not intend to refund surcharges that have been made since the first of the year, and we will continue to include in renewal requirements estimates of this additional liability. We have no alternative, Don, but to price this thing based on the liability we know we have under the law."[20]

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[18]Memorandum of Marilyn Shelley to Dana Reynolds dated March 5, 1985.

[19]Letter from Donald Reardon to Charlie Griffith dated September 8, 1983.

[20]Letter from Charlie Griffith to Donald Reardon dated September 13, 1983.

Provident apparently had reason to believe that that day may be a long time coming. Reardon also stated in the letter to Griffith: "It is quite obvious to everyone that Medicare has no way of knowing who in their claim files is an active employee working for an employer of 15 or more employees. Consequently, they never will be able to track this down and pass it back to the insurance industry."[21]

Provident documents indicate that Provident went beyond instructing its employees to evade primary payer responsibility after TEFRA; Provident also advised its large employer customers not to reimburse money owed to Medicare. For example, one of Provident's customers, the Campbell Soup Company requested that Provident provide it with " a write-up on how you desire Medicare to be reimbursed in cases where we have provided benefits on a secondary basis."[22] In response to this letter, Provident stated: "TEFRA does not require, and we do not suggest that anything be initiated regarding unsolicitated [sic] reimbursement. We feel this is up to Medicare based on the regulations, and they have the option of requesting or not requesting reimbursement."[23]

Allegations about the failure of some insurance companies to comply with the MSP laws came to the attention of the federal government through the filing of a lawsuit by a private individual under the False Claims Act in 1988. The Justice Department has also instituted civil lawsuits against several insurance companies for alleged abusive practices in connection

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[21]Letter from Donald Reardon to Charlie Griffith dated September 8, 1983.

[22]Letter from R.E. Grossman, Director, Employee Benefits, Campbell Soup Company, dated June 29, 1983.

[23]Letter from Ray Millard to Ray Grossman, dated July 6, 1983.

with the handling MSP claims, and is seeking to recoup millions of dollars owed by insurance companies as a result of these alleged practices.[24]

The insurance companies assert that Congress shares at least partial responsibility for the disarray of the MSP program because of repeated piecemeal changes to the Medicare statutes. The insurance companies also complain that providers, especially hospitals, are making order of benefits determinations that they are not competent to make. This results in billing the incorrect party, which, of course, ultimately delays payment of the claim.

GAO has taken the position that insurance companies are in the best position to know who they insure and that they are therefore in the best position to determine which beneficiaries fall into the MSP categories. Some insurance companies, to the contrary, assert that because of the varied arrangements they have with employers and the size of some of the accounts, they often have no clear idea as to who are their insureds until a claim is filed. In situations where the insurance companies provide administrative services only, they may not even retain the beneficiary files.

Nevertheless, the critical deficiency in MSP compliance is the absence of necessary information about beneficiaries who are subject to the MSP program. The most direct solution may be to require either insurance companies or employers, depending on which maintains the beneficiary files, to report to the

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[24] See United States v. Blue Cross Blue Shield of Michigan, 726 F. Supp. 1517 (E.D. Mich. 1989) (declaratory reimbursement action); United States v. Provident Life and Accident Insurance Company, No. 1-89-316 (E.D. Tenn., filed April 5, 1989) (declaratory reimbursement action); United States v. Travelers' Insurance Company, No. H-89-271 (JAC) (D. Conn. filed March 13, 1990) (declaratory reimbursement action).

government those employees who have health coverage who fall into MSP categories.

CONCLUSIONS

There are failures at each level of the MSP process that prevent the MSP program from functioning properly.

A. Hospitals must improve the collection of data from patients. Hospital billing offices must submit bills that correspond to the data collected. The misuse of HCFA codes by hospitals must stop immediately.

B. Given the enormous sums of money the government continues to lose on the MSP program, there should be an accommodation between speedy claims processing by Medicare and adequate pre-claim development. This may be achieved by HCFA issuing regulations requiring that additional information such as dates of beneficiary employment and information regarding a spouse's employer be provided to Medicare. C-PEP evaluations need to be a more realistic guideline of contractor performance.

C. Insurance companies must establish procedures to process MSP claims properly. HCFA should maintain an aggressive program for recovering improper MSP payments.

D. Insurance companies and/or employers, where appropriate, should be required to report periodically to HCFA information concerning employees who have employer group health plans and for whom Medicare is a secondary payer.

STATEMENT BY

MICHAEL MANGANO

DEPUTY INSPECTOR GENERAL FOR EVALUATION

AND INSPECTIONS

OFFICE OF INSPECTOR GENERAL

FOR THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

COMMITTEE ON GOVERNMENTAL AFFAIRS

JULY 11, 1990

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS. I AM ACCOMPANIED THIS MORNING BY LARRY SIMMONS, ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE FINANCING AUDITS AND BOB SIMON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS. WE ARE HERE, AT YOUR REQUEST, TO DISCUSS WITH YOU THE MEDICARE AS SECONDARY PAYER (MSP) PROVISIONS. I WOULD LIKE TO BEGIN BY BRIEFLY DESCRIBING: (1) THE HISTORY OF THE MSP PROGRAM; (2) RECENT WORK THAT HAS BEEN CONDUCTED BY THE OFFICE OF INSPECTOR GENERAL (OIG); (3) AUDIT, EVALUATION, AND INVESTIGATIVE ACTIVITIES THAT HAVE RESULTED FROM NONCOMPLIANCE WITH THE MSP PROVISIONS; AND (4) ADDITIONAL MEASURES WHICH CAN BE TAKEN TO ENSURE THAT THE MSP PROGRAM FUNCTIONS AS INTENDED BY THE CONGRESS.

BACKGROUND

MEDICARE WAS ESTABLISHED IN 1965 WITH THE ESTABLISHMENT OF TITLE XVIII OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395 ET. SEQ.) TO

PAY FOR HEALTH CARE SERVICES FOR ELIGIBLE BENEFICIARIES AGE 65 AND OLDER. FOR THE FIRST 15 YEARS OF THIS PROGRAM, MEDICARE WAS THE PRIMARY OR FIRST PAYER FOR ALL HEALTH CLAIMS EXCEPT WHEN THE CLAIMANT WAS COVERED BY WORKERS' COMPENSATION, BLACK LUNG OR VETERANS BENEFITS. BETWEEN 1980 AND 1986, CONGRESS PASSED A SERIES OF STATUTORY PROVISIONS WHICH ESTABLISHED MEDICARE AS THE SECONDARY PAYER TO OTHER INSURERS IN CERTAIN SITUATIONS. APPENDIX A CONTAINS A SUMMARY OF THESE AUTHORITIES AND THE ACTIONS TAKEN TO IMPLEMENT THEM. IN GENERAL, THESE AUTHORITIES, CODIFIED AT 42 USC 1395 (Y)(B), MAKE MEDICARE SECONDARY PAYER TO:

- COVERAGE UNDER AN AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE PLAN (OMNIBUS RECONCILIATION ACT OF 1980);

- EMPLOYER GROUP HEALTH PLAN (EGHP) COVERAGE OF BENEFICIARIES WHO HAVE KIDNEY FAILURE (END STAGE RENAL DISEASE) DURING THEIR FIRST YEAR OF MEDICARE ENTITLEMENT (OMNIBUS BUDGET RECONCILIATION ACT OF 1981);

- COVERAGE UNDER AN EGHP (PROVIDED BY AN EMPLOYER OF 20 OR MORE PERSONS) OF WORKING BENEFICIARIES AGE 65 OR OLDER OR THEIR SPOUSES (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 AS AMENDED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985); AND

- COVERAGE UNDER AN EGHP PROVIDED BY AN EMPLOYER OF 100 OR MORE PERSONS FOR BENEFICIARIES WHO ARE DISABLED (OMNIBUS BUDGET RECONCILIATION ACT OF 1986).

UNDER CURRENT PROCEDURES, PROVIDERS ARE REQUIRED TO ASK MEDICARE BENEFICIARIES A SERIES OF QUESTIONS CONCERNING THEIR HEALTH INSURANCE COVERAGE WHEN THE BENEFICIARY IS ADMITTED TO THE HOSPITAL OR WHEN ANY OTHER NON-HOSPITAL SERVICE IS RENDERED. PROVIDERS ARE THEN REQUIRED TO BILL OTHER INSURERS FIRST WHEN BENEFICIARIES FALL WITHIN ONE OF THE MSP CATEGORIES DESCRIBED EARLIER.

MEDICARE CONTRACTORS ARE REQUIRED TO SCREEN ALL CLAIMS FOR COVERAGE BY ANOTHER INSURER. THIS IS DONE BY SEARCHING HISTORY FILES, QUERYING REGIONAL MSP DATA BASES, AND

CONTACTING BENEFICIARIES DIRECTLY TO DEVELOP INFORMATION SUCH AS ACCIDENT LIABILITY AND OTHER INSURANCE INFORMATION.

NUMEROUS STUDIES CONDUCTED BY OIG, GAO AND HCFA HAVE SHOWN THAT DESPITE LEGISLATION MAKING MEDICARE THE SECONDARY PAYER IN CERTAIN SITUATIONS, MEDICARE CONTINUES TO BE BILLED AS PRIMARY PAYER. WE HAVE CONDUCTED 26 SEPARATE EVALUATIONS AND AUDITS CONCERNING MSP SINCE MARCH 1984. IF THERE IS NO OBJECTION, WE WOULD LIKE TO SUBMIT FOR THE RECORD COPIES OF THESE REPORTS. A LIST OF THESE REPORTS IS CONTAINED IN APPENDIX B. THE HCFA HAS TAKEN A NUMBER OF ACTIONS TO IMPROVE METHODS FOR IDENTIFYING CASES WHERE A PRIMARY PAYMENT SOURCE EXISTS. WE HAVE INCLUDED SUMMARIES OF HCFA'S MAJOR INITIATIVES IN APPENDIX C. DESPITE THESE EFFORTS, PROBLEMS STILL EXIST. WE ESTIMATE THAT BETWEEN $400 AND $600 MILLION PER YEAR WAS LOST TO MEDICARE IN INAPPROPRIATE PAYMENTS IN 1988 AND RECENT INFORMATION SUGGESTS THAT CURRENT PROGRAM LOSSES MAY BE EVEN HIGHER.

RECENT MSP WORK CONDUCTED BY OIG

I WOULD LIKE TO BRIEFLY DESCRIBE SOME OF OUR MORE RECENT WORK IN THIS AREA:

- O IN 1988, THE OIG PUBLISHED A SERIES OF REPORTS COVERING END-STAGE RENAL DISEASE, AUTOMOBILE ACCIDENTS AND RELATED CLAIMS, AND MEDICARE BENEFICIARIES COVERED BY EMPLOYER GROUP HEALTH PLANS, WHICH WERE NATIONWIDE IN SCOPE, AND WHICH DOCUMENTED A TOTAL OF ABOUT $263 MILLION IN PROJECTED LOSSES TO MEDICARE.

- O IN ANOTHER 1988 REPORT, *NATIONWIDE REVIEW OF MEDICARE AS SECONDARY PAYER FOR THE PERIOD SEPTEMBER 1, 1983 THROUGH NOVEMBER 30, 1985* (A-10-86-62005), THE OIG IDENTIFIED (THROUGH A SEPARATE SAMPLE) ANOTHER $20.8 MILLION IN OVERPAYMENTS BECAUSE MEDICARE PAID WHEN OTHER INSURANCE PLANS SHOULD HAVE BEEN PRIMARY PAYERS.

- O IN A FEBRUARY 1990 REPORT, THE OIG RECOMMENDED THAT THE DEPARTMENT PROPOSE LEGISLATION TO ESTABLISH A

VOLUNTARY DISCLOSURE AND RECOVERY PROGRAM. THE PROGRAM WOULD PERMIT INSURERS, EMPLOYERS (ESPECIALLY SELF-INSURED AND SELF-ADMINISTERED EMPLOYERS) OR THIRD-PARTY ADMINISTRATORS, ACTING WITHIN 1 YEAR OF ENACTMENT, TO IDENTIFY INSTANCES OF IMPROPER MSP PAYMENTS AND MAKE RESTITUTION OF THE APPROPRIATE AMOUNTS (WITH INTEREST AND COSTS), WITHOUT THREAT OF FUTURE GOVERNMENT ACTION *WITH RESPECT TO THOSE CLAIMS.*

- IN MARCH 1990, THE OIG ISSUED A FINAL MANAGEMENT ADVISORY REPORT ENTITLED *MORE COMPLETE EMPLOYER GROUP HEALTH PLAN INFORMATION IS NEEDED TO ADMINISTER THE MEDICARE SECONDARY PAYER PROGRAM* (A-09-89-00100). THIS REPORT IDENTIFIED A MATERIAL INTERNAL CONTROL WEAKNESS IN THE MSP PROGRAM WHICH WAS INCLUDED IN THE SECRETARY'S 1989 FINANCIAL INTEGRITY ACT REPORT TO THE PRESIDENT AND THE CONGRESS.

- TWO WEEKS AGO, WE ISSUED A MANAGEMENT ADVISORY REPORT ENTITLED *MEDICARE SECONDARY PAYER: UNRECOVERED FUNDS* (OEI-07-90-00764). IN THIS STUDY WE ANALYZED THE RESPONSES

RECEIVED FROM A NATIONAL RANDOM SAMPLE OF OVER 3,000 MEDICARE BENEFICIARIES CONCERNING THEIR HEALTH INSURANCE COVERAGE AND AUTOMOBILE AND OTHER ACCIDENT EXPERIENCES. WE FOUND THAT, WHILE PROGRESS HAS BEEN MADE IN IDENTIFYING MSP SITUATIONS, BETWEEN $400 AND $600 MILLION IN INAPPROPRIATE MEDICARE PAYMENTS WERE MADE IN 1988.

- WE HAVE ISSUED A MANAGEMENT ADVISORY REPORT ENTITLED *OVERVIEW OF MEDICARE SECONDARY PAYER SYSTEMS: STRATEGIES FOR IMPROVEMENT* (OAI-07-90-00740). THIS REPORT PRESENTED AN OVERVIEW OF CURRENT SYSTEMS USED BY HCFA AND THE CHALLENGES FACING ITS CONTRACTORS IN THE IDENTIFICATION OF MSP SOURCES, RECOVERY OF INAPPROPRIATELY PAID FUNDS, TRAINING AND OUTREACH ACTIVITIES, AND HCFA'S EVALUATION AND OVERSIGHT OF THESE ACTIVITIES.

ONGOING ACTIVITIES AND INVESTIGATIVE CASES

AS YOU KNOW, THE OIG IS RESPONSIBLE FOR INVESTIGATING *QUI TAM* LAW SUITS WHICH INVOLVE ALLEGATIONS OF FRAUD PERTAINING TO DEPARTMENTAL PROGRAMS. IN THESE LAW SUITS, ANY PERSON HAVING KNOWLEDGE OF A FALSE CLAIM AGAINST THE GOVERNMENT MAY BRING AN ACTION IN A FEDERAL DISTRICT COURT FOR THEMSELVES ON BEHALF OF THE GOVERNMENT, PURSUANT TO THE *QUI TAM* PROVISIONS OF THE FALSE CLAIMS ACT, 31 USC 3729-3733. EACH TIME A *QUI TAM* CASE IS FILED AND SENT UNDER SEAL TO THE DEPARTMENT OF JUSTICE (DOJ) TO CONSIDER WHETHER THE GOVERNMENT SHOULD TAKE OVER PROSECUTION OF THE CASE ON ITS OWN BEHALF, DOJ CONTACTS OIG TO CONDUCT AN INVESTIGATION AND MAKE A REPORT AND RECOMMENDATION TO DOJ. THE OIG HAS THUS FAR CONDUCTED FIVE MSP INVESTIGATIONS RELATED TO SUITS FILED UNDER THE *QUI TAM* FALSE CLAIMS ACT. IN EACH CASE WE RECOMMENDED THAT THE GOVERNMENT NOT JOIN THE *QUI TAM* SUIT BUT INSTEAD RESERVE THE RIGHT TO INTERVENE AT A LATER TIME IF APPROPRIATE.

OUR PROBLEMS IN PURSUING CRIMINAL CASES FOR VIOLATING THE MSP PROVISIONS CAN BE ILLUSTRATED BY OUR EXPERIENCE IN A RECENT MAJOR INVESTIGATION. WE INITIATED A CRIMINAL INVESTIGATION OF PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY IN MARCH 1988. IT WAS ALLEGED IN A LAW SUIT FILED BY A PRIVATE LAW FIRM UNDER THE "QUI TAM" PROVISIONS, THAT THE INSURER HAD DEFRAUDED THE MEDICARE PROGRAM BY INTENTIONALLY PAYING BENEFITS AS SECONDARY TO MEDICARE WHEN THE INSURER WAS AWARE THAT THEY HAD PRIMARY LIABILITY IN NUMEROUS CASES.

AS PART OF OUR INVESTIGATIVE PROCESS, WE ISSUED A SUBPOENA FOR THEIR FILES CONCERNING PAYMENT FOR INFORMATION ABOUT 250 RANDOMLY SELECTED BENFICIARIES. UNFORTUNATELY THE INSURER FAILED TO PROVIDE THE REQUESTED RECORDS. THE INSURER MAINTAINED THAT IT WAS UNABLE TO PRODUCE THE REQUESTED RECORDS AND NO HEARING WAS HELD TO FORCE THE INSURER'S COMPLIANCE. ALMOST AFTER TWO YEARS OF WORK WE HAVE RECENTLY BEEN NOTIFIED THAT DOJ HAS DECLINED TO PROSECUTE THE CASE WHICH WAS SUBMITTED IN TWO SEPERATE JURISDICTIONS. ONE ASSISTANT US ATTORNEY STATED THAT THE DECLINATION WAS DUE TO MANPOWER SHORTAGES. IN THE OTHER JURISDICTION THE

ASSISTANT US ATTORNEY DECLINED IN FAVOR OF A CIVIL RECOVERY ACTION AGAINST THIS INSURER FOR INAPPROPRIATE PAYMENTS MADE BY THE MEDICARE PROGRAM.

WE ARE CURRENTLY AUDITING FIVE MEDICARE CONTRACTORS TO DETERMINE IF THEY ARE COMPLYING WITH MSP PROVISIONS AND PROCEDURES AND TO DETERMINE THE AMOUNT OF IMPROPER MEDICARE PRIMARY PAYMENTS. THESE REVIEWS ARE BEING CONDUCTED AT AETNA INSURANCE COMPANY, TRAVELERS INSURANCE COMPANY, EMPIRE BLUE CROSS-BLUE SHIELD, BLUE CROSS AND BLUE SHIELD OF FLORIDA, AND BLUE CROSS BLUE SHIELD OF MICHIGAN. THE OIG HAS ISSUED SUBPOENAS TO EACH COMPANY, AND, IN THE CASE OF MICHIGAN AND TRAVELERS, IS WORKING WITH THE DEPARTMENT OF JUSTICE WHICH HAS FILED SUIT FOR COLLECTION OF MSP PAYMENTS.

WE ALSO CONDUCTED A COMPUTER MATCH OF HCFA AND SOCIAL SECURITY ADMINISTRATION RECORDS TO DETERMINE THE TOTAL AMOUNT OF MEDICARE PAYMENTS THAT SHOULD HAVE BEEN THE PRIMARY LIABILITY OF THE INSURER. THIS MATCH BEGAN IN EARLY 1989 TO CREATE A DATA BASE OF MEDICARE ELIGIBLE WORKERS FROM

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WHICH MSP SITUATIONS COULD BE IDENTIFIED. WE IDENTIFIED FROM SSA EARNINGS RECORDS AND FROM HCFA'S MEDICARE BENEFICIARY HISTORY AND PAID CLAIMS FILES, ABOUT 8 MILLION MEDICARE BENEFICIARIES WHO WORKED FOR 1.1 MILLION EMPLOYERS, WHO HAD EARNINGS AND COULD HAVE BEEN COVERED BY EMPLOYER HEALTH PLANS.

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (OBRA '89) MANDATES THE TRANSFER OF MSP INFORMATION BETWEEN THE INTERNAL REVENUE SERVICE (IRS), SSA AND HCFA AND REQUIRES FISCAL INTERMEDIARIES AND CARRIERS TO CONTACT QUALIFIED EMPLOYERS TO DETERMINE WHAT PERIODS THE EMPLOYEE OR EMPLOYEE'S SPOUSE ARE COVERED UNDER AN EGHP AND THE NATURE OF THE COVERAGE. THE REQUIRED OBRA '89 MATCH IS, FOR THE MOST PART, SIMILAR TO THE OIG COMPUTER MATCH. THUS, WE ARE USING OUR MATCH WORK TO HELP HCFA IN ITS IMPLEMENTATION OF OBRA '89.

WHAT ACTIONS STILL NEED TO BE TAKEN?

ALTHOUGH IMPLEMENTATION OF THE OBRA '89 PROVISIONS WILL HELP IDENTIFY AND PREVENT MSP OVERPAYMENTS, ADDITIONAL ACTION IS

NECESSARY. THE FOLLOWING OIG RECOMMENDATIONS WE HAVE MADE TO HCFA WOULD ALSO HELP CORRECT MSP PROBLEMS:

LEGISLATIVE ACTIONS

O LAST YEAR, IN ITS FY 1990 LEGISLATIVE AGENDA, THE DEPARTMENT CONSIDERED A LEGISLATIVE PROPOSAL WHICH WOULD REQUIRE EGHP TO NOTIFY HCFA ABOUT COVERED INDIVIDUALS WHO ARE OVER AGE 65 AND ENROLLED IN INSURANCE PROGRAMS TO WHICH MEDICARE IS SECONDARY PAYER. IF AN INSURER FAILED TO NOTIFY HCFA, IT WOULD BE POTENTIALLY SUBJECT TO A CIVIL MONETARY PENALTY OF UP TO $10,000. THIS PROPOSAL WAS NOT INCLUDED IN THE LEGISLATIVE PACKAGE FORWARDED TO THE CONGRESS WITH THE FY 1990 BUDGET. THE OIG HAS RECOMMENDED THAT HCFA REWRITE THE JUSTIFICATION FOR THE LEGISLATIVE PROPOSAL AND STATE THAT ENACTMENT OF THE PROPOSAL WOULD CORRECT THE MATERIAL INTERNAL CONTROL WEAKNESS IDENTIFIED BY THE OIG. THE DEPARTMENT IS CURRENTLY CONSIDERING INCLUDING THE PROPOSAL IN ITS FY 1992 LEGISLATIVE PROGRAM.

ALTERNATIVELY, THIS COULD BE ABSORBED INTO A BROADER PROPOSAL TO ESTABLISH A NATIONAL CLEARINGHOUSE OF INFORMATION PERTAINING TO MEDICAL INSURANCE AVAILABLE TO BENEFICIARIES OF ALL FEDERAL AND STATE PROGRAMS. UNDER THIS PROPOSAL HCFA WOULD RUN ITS CLAIMS INFORMATION THROUGH THIS CLEARINGHOUSE IN ORDER TO IDENTIFY MSP SITUATIONS.

- ACTION SHOULD BE TAKEN TO COLLECT MORE ACCURATE AND TIMELY INFORMATION TO IDENTIFY PRIMARY PAYERS, INCLUDING MODIFYING W-2 FORMS TO COLLECT EGHP INFORMATION. THE HCFA IS EVALUATING THIS RECOMMENDATION AS A POSSIBLE ALTERNATIVE TO THE OBRA '89 REQUIRED MATCH WITH IRS.

- THE DEPARTMENT SHOULD SEEK LEGISLATION TO ESTABLISH A VOLUNTARY DISCLOSURE AND RECOVERY PROGRAM. THE PROGRAM WOULD PERMIT INSURERS, EMPLOYERS, OR THIRD-PARTY ADMINISTRATORS, TO IDENTIFY INSTANCES OF IMPROPER MSP PAYMENTS AND MAKE RESTITUTION OF THE AMOUNTS WITHOUT THREAT OF FUTURE GOVERNMENT ACTION WITH RESPECT TO THOSE CLAIMS. THE LEGISLATION SHOULD ALSO

PROVIDE FOR A WAIVER OF THE EXISTING STATUTE OF LIMITATIONS CONCERNING IMPROPER MSP PAYMENTS. ANY INSURER NOT PARTICIPATING IN THIS PROGRAM WOULD BE SUBJECT TO TREBLE DAMAGES, PLUS COSTS, WITH RESPECT TO ALL IMPROPER MSP CLAIMS LATER IDENTIFIED BY THE GOVERNMENT.

- THE DEPARTMENT SHOULD SEEK LEGISLATION TO REQUIRE MEDICARE CONTRACTORS TO MATCH THEIR HEALTH INSURANCE DATA WITH MEDICARE FILES. SEVERAL YEARS AGO, WE RECOMMENDED THAT THIS MATCHING ACTIVITY BE REQUIRED BY THE HCFA. THIS RECOMMENDATION WAS BASED ON OUR BELIEF THAT CONTRACTORS HAVE A FIDUCIARY RESPONSIBILITY TO THE FEDERAL GOVERNMENT TO ASSURE THAT ONLY APPROPRIATE MEDICARE PAYMENTS ARE MADE. IT FOLLOWS THAT, CONTRACTORS, BY FAILING TO MATCH THEIR PRIVATE INSURANCE FILES WITH MEDICARE FILES ARE BREACHING THIS RESPONSIBILITY AND CREATING A CONFLICT OF INTEREST. IN OBRA OF 1989, CONGRESS PROHIBITED HCFA FROM IMPLEMENTING THIS MATCHING ACTIVITY. WE CONTINUE TO BELIEVE THAT THIS MATCHING ACTIVITY IS APPROPRIATE AND CONSISTENT WITH THE

CONTRACTOR'S FIDUCIARY RESPONSIBILITY TO THE GOVERNMENT.

REGULATORY ACTIONS

WE HAVE RECOMMENDED THAT HCFA TAKE ADMINISTRATIVE ACTION TO:

- REVISE ALL MEDICARE CLAIM FORMS TO REQUIRE AN ANSWER OF "YES" OR "NO" TO THE QUESTION, "DO YOU HAVE HEALTH INSURANCE AS A RESULT OF YOUR, OR YOUR SPOUSE'S CURRENT EMPLOYMENT?"

- AMEND INSTRUCTIONS TO MEDICARE CONTRACTORS TO SPECIFY THAT IF THE SECTION ON THE CLAIM FORM PERTAINING TO EMPLOYEE INSURANCE IS BLANK, THE CLAIM SHOULD BE SUSPENDED AND RETURNED EXPLAINING THAT THE OTHER HEALTH INSURANCE COVERAGE QUESTION MUST BE ANSWERED.

- DEVELOP THE FIRST CLAIM FILED BY A BENEFICIARY EACH YEAR FOR POTENTIAL OTHER PRIMARY SOURCES OF HEALTH

INSURANCE COVERAGE. THE HCFA HAS ASKED OIG FOR COST-BENEFIT ANALYSIS OF THIS PROPOSAL. WE SHOULD HAVE THIS ANALYSIS COMPLETED BY THIS SUMMER.

- CONTINUE TO PURSUE THE FY 1991 BUDGET REQUEST, IN AN ATTEMPT TO INCREASE THE RESOURCES AVAILABLE FOR MSP ACTIVITIES. IF THE FY 1991 FUNDING INCREASE IS NOT APPROVED, ALTERNATIVE FUNDING ACTION SHOULD BE CONSIDERED.

FINALLY, WE HAVE RECOMMENDED THAT THE SOCIAL SECURITY ADMINISTRATION MAINTAIN SPOUSAL INFORMATION IN ITS MASTER BENEFICIARY RECORD. THE HCFA IS EVALUATING THIS RECOMMENDATION AS AN ALTERNATIVE TO THE IRS MATCH.

CONCLUSION

THE MSP PROVISIONS WERE ENACTED AS A RESULT OF SIGNIFICANT INCREASES IN MEDICARE COSTS. SHIFTING THE RESPONSIBILITY FOR HOSPITAL AND MEDICAL CLAIMS TO THOSE PRIVATE PLANS COVERING THE "WORKING AGED" OR INJURIES ARISING FROM ACCIDENTS WAS SEEN AS EQUITABLE AND NECESSARY IN LIGHT OF THE NEED TO

CONTROL SPIRALING MEDICARE EXPENDITURES.

UNFORTUNATELY, THE IMPLEMENTATION OF THE MSP PROVISIONS HAS NOT MET THE GOALS INTENDED BY THE CONGRESS. STUDIES BY THE OIG, GAO AND HCFA HAVE SHOWN THAT HUNDREDS OF MILLIONS OF DOLLARS ARE STILL LOST EACH YEAR BECAUSE MSP SITUATIONS CANNOT BE ADEQUATELY IDENTIFIED AND PURSUED. ACTIONS BY HCFA, WHILE ACHIEVING SAVINGS OF $1.4 BILLION IN FY 1988, HAVE NOT ELIMINATED THE PROBLEMS.

IN THIS TESTIMONY WE HAVE OUTLINED NUMEROUS ACTIONS WHICH COULD RESULT IN SUBSTANTIAL RECOVERIES AND INSURE THAT THE MSP PROVISIONS ARE ACHIEVING THE GOALS INTENDED BY CONGRESS.

THIS CONCLUDES MY TESTIMONY. I AM AVAILABLE TO ANSWER YOUR QUESTIONS.

APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Omnibus Reconciliation Act of 1980 (ORA)	95-499	12-05-80	06-06-83	ORA made Medicare the secondary payer for automobile accident related claims.
Omnibus Budget Reconciliation Act of 1981 (OBRA 81)	97-035	08-13-81	01-01-83	OBRA-81 made Medicare benefits secondary to EGHPs for beneficiaries with end stage renal disease.
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	97-248	09-03-82	01-01-83	TEFRA made Medicare benefits secondary if the employee or spouse is age 65 through 69 covered by an EGHP and the employer has at least 20 employees.
Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA 86)	99-509	10-21-86	01-01-87	OBRA-86 made Medicare items and services secondary for payment if the disabled beneficiary or spouse is working and covered under an EGHP.

APPENDIX A - Cont.

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Omnibus Budget Reconciliation Act of 1989 (OBRA 89)	101-239	12-19-89	12-19-89	OBRA-89 provided a two year period for matching IRS tax records to records of the Social Security Administration and the Health Care Financing Administration to identify working beneficiaries and their spouses.

APPENDIX B

PREVIOUSLY PUBLISHED REPORTS

1. Priority Audit Memorandum - Survey of the Tax Equity and Fiscal Responsibility Act of 1982 - March 7, 1984, Control Number: ACN-03-42009

2. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - August 24, 1984, Control Number: 1-07-4001-14

3. Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota - November 20, 1984, Control Number: 1-08-4009-14

4. Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado - December 4, 1984, Control Number: 1-08-4001-14

5. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - April 3, 1985, Control Number: 1-07/08-4002-14

6. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota - May 1, 1985, Inspection Control Number: 03-08-5001-14

7. Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon - May 10, 1985, Inspection Control Number: 3-10-4008-14

8. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - June 1985, Control Number: 1-01-4105-31

9. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - Boston - June 1985, Control Number: 1-01-4105-32

10. Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri - Program Inspection Report - December 1985, Control Number: 3-07-5001-32

11. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado - Program Inspection Report - December 1985, Control Number: 3-08-5002-14

12. Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts, Control Number: OPI-85-070-040

13. Medicare Secondary Payer Provision Working Aged in Missouri - July 1986, Control Number: P-07-86-00079

14. Medicare Secondary Payer Provision Working Aged in Colorado - July 1986, Control Number: P-07-86-00071

15. OIG Audit Report - Medicare Overpayments for Services Provided to Beneficiaries with End-Stage Renal Disease - April 28, 1987, Control Number: A-10-86-62003

16. OIG Audit Report - Retirees of Exempt State and Local Government Could Cost Medicare $12.8 Billion over the next 5 Years - September 10, 1987, Control Number: CIN A-09-86-62050

17. Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years - December 1, 1987, Control Number: CIN A-10-86-62016

18. Medicare as a Secondary Payment Source - End-State Renal Disease - January 1988, Control Number: OAI-07-86-00092

19. Medicare as a Secondary Payment Source - January 1988, Control Number: OAI-07-86-00017

20. Medicare as a Secondary Payment Source - Medicare Beneficiaries Covered By Employer Group Health Plans - February 1988, Control Number: OAI-07-86-00091

21. Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985, Control Number: CIN A-10-86-62005

22. Management Advisory Report: Medicare as Secondary Payer -Restitution Proposal, Control Number: AO-12-89-00002

23. Management Advisory Report: More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program, Control Number: A-09-89-00100

24. Draft Management Advisory Report: MSP Survey - Contractors Questionnaire, Control Number: A-09-89-00151

25. Exposure Draft OIG Management Advisory Report: Overview of Medicare Secondary Payer Systems: Strategies for Improvement, Control Number: OAI-07-90-00740

26. Management Advisory Report: Medicare Secondary Payer: Unrecovered Funds, Control Number: OEI-07-90-00764

APPENDIX C

MEDICARE SECONDARY PAYER INITIATIVES CONDUCTED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Contractor Data Match

In 1984, HCFA piloted two types of computer matches (matching enrollment records and matching claims records) plus a general mailing approach to determine if any of these were effective methods of identifying MSP situations. Fifteen contractor sites were included in these tests. Results of the pilots indicated that matching enrollment records was the more effective matching technique, producing a rate of return of between $5 and $8 recovered for each dollar spent as compared to a recovery rate of between $4 and $6 using the claims matching methodology. However, inasmuch as systems differences among contractors limited its applicability at the time, it was not implemented as a national requirement.

Beneficiary Questionnaires

In 1985, HCFA required Medicare contractors to send 65 to 69 year old beneficiaries a questionnaire requesting employment status, private employer health insurance information, spouse's employment status, age, and employer health insurance information. The mailing was determined to be a cost effective method of identifying new MSP sites. Test results indicated a 5 percent new identification rate on these mailings and a rate of return of between $32 and $48 saved for every dollar spent.

Data Matches with Workers' Compensation Agencies

In 1986, HCFA advised Medicare contractors to obtain information from State Workers' Compensation agencies and to match that information against beneficiary records to detect those instances where workers' compensation was involved in the need for medical care. If a match occurs, the contractor determines whether Workers' Compensation should have been the primary payer and seeks to recover erroneously paid benefits. At contractors where such information exchanges have been negotiated (approximately 15) savings have increased by approximately 25 percent.

HCFA/SSA MSP Pilot Project

Also in 1986, HCFA tested the feasibility of identifying, through existing information channels at SSA, employment related health insurance that is primary to Medicare. The information was collected at the time of application for retirement benefits and furnished to contractors as potential MSP leads. The pilot was conducted in six States and furnished strong indicators that this process is a successful method of identifying beneficiaries who fall under the various MSP provisions. SSA has requested further study of this pilot while they develop an automated system for collecting and transmitting retirement data.

Regional Data Exchange System (RDES)

In 1987, HCFA implemented a regional MSP exchange of information system. Under this procedure, MSP information is gathered from all contractors within the region by a Regional Data Exchange manager who compiles all information and distributes it to the contractors in the Region. This information is also available, upon request, to contractors outside the Region. This MSP data base identifies beneficiaries that have a confirmed primary insurer other than Medicare. Sharing information reduces development of a claims by multiple contractors and ensures prepayment denial of MSP claims.

First Claim Development

In 1987, HCFA established a procedure which requires contractors to send a letter to each beneficiary age 65 or 66 when the contractor receives a claim from that beneficiary and no previous activity was noted and information on the billing form is incomplete. The letter explains the MSP provisions and asks that the beneficiary provide information on any coverage they maintain which might be primary to Medicare. This is the best method in use today to initially identify persons who have other insurance coverage and to keep existing data bases up to date.

Outreach Educational Campaign

In 1988, HCFA developed an educational package describing the MSP program and mailed it to over 500,000 physicians across the country. HCFA also developed a series of public service announcements for radio and television designed to make Medicare beneficiaries aware of Medicare Secondary Payer. These are currently being broadcast in the 30 largest television markets. Based on a follow-up survey we know that physicians and their staffs found the material informative and useful, and that the PSAs were being aired in many time slots on a continuing basis.

PREPARED STATEMENT OF
LUIS C. BUSTAMANTE

I. **INTRODUCTION**

My name is Luis C. Bustamante and I am an attorney licensed to practice law in the State of Florida and Texas. I am a member of the law firm of Stinson, Lyons, Gerlin & Bustamante, P.A. with offices located at 1401 Brickell Avenue, Suite 900, Miami, Florida. I represent the interest of the law firm as a relator pursuant to the False Claims Act of 1986 in connection with litigation brought against Provident Life & Accident Insurance Company as well as other members of the insurance industry.

II. **STATEMENT OF FACTS**

Our firm first became interested in the activities of Provident Life & Accident Insurance Company as it relates to the Medicare Secondary Payer Program in March of 1983 when the firm represented the interests of a client who was entitled to benefits under a group policy issued by Provident Life & Accident Insurance Company.

Investigation conducted by our firm since March of 1983 yielded evidence establishing the fact that Provident has taken advantage of the Medicare system and in particular, the Medicare Secondary Payer Program.

Provident, as an insurance company, sells, administers and issues employer group health plans (EGHP) to a variety of companies throughout the United States. These policies provide comprehensive medical expense benefits for the company's employees, their spouses, dependents and other individuals related to the particular

company insured under the group policy. Prior to January 1, 1983, under the standard EGHP issued or administered by Provident, Provident coordinated its medical care benefits with Medicare where an insured was eligible to receive Medicare benefits. The effect of this coordination was for Medicare to pay up to 80% of the total amount of any given medical bill provided the insured was eligible to receive Medicare benefits. Provident's obligation to process for payment and pay medical benefits was limited to sums in excess of the amount payable by Medicare. In other words, for insureds eligible for Medicare, Medicare was the primary source of payment and Provident, secondary.

In 1982, in an effort to reduce federal spending, Congress enacted legislation which shifted the primary/secondary responsibility as between Medicare and EGHPs such as the ones insured or administered by Provident. Thus, where Medicare was the primary source of benefits for the working aged prior to 1983, private EGHPs were required to become primary after 1983. The primary responsibility for the working aged and their spouses was shifted from the government (Medicare) to the private sector. Since January 1, 1983, the overall effect of the Medicare Secondary Payer Program is to establish Provident's obligation to process for payment or pay medical benefits for the working aged and their spouses on a primary basis.

III. SOURCE OF INFORMATION

In March of 1983 our firm was requested to represent the interests of a client as a result of an automobile accident. At

the time of this accident, our client was an insured under a group health policy issued by Provident Life and Accident Insurance Company.

In an attempt to resolve numerous legal matters concerning the automobile accident, I had an opportunity to review and process for payment various insurance claims for medical expenses incurred as a result of the accident. After reviewing the facts and circumstances, the firm concluded that the claims handling practices implemented by Provident violated federal law. Based on the information originally gathered through the investigation of our client's claim for group health benefits, I wrote a letter to the Honorable Claude Pepper on December 5, 1984 since it was apparent that the insurance industry was collecting premiums as a result of their obligation to pay the medical expenses of the working aged; however, the insurance companies were limiting their exposure by relying upon Medicare. See, Exhibit "A".

Since December 5, 1984 our law firm has communicated with agents and representatives of the government on numerous occasions in order to apprise the government of the facts and circumstances relating to the scheme implemented by Provident and other insurers in order to take advantage of the Medicare system.

The information gathered established without question that Provident knowingly made, used, submitted or caused to be made, used and submitted false and fraudulent claims and statements for purposes of avoiding and concealing its obligation to process for payment and pay the medical expenses of the working aged on a

primary basis thereby depriving the Medicare system of money that rightfully belongs to the government.

IV. **PROVIDENT'S KNOWLEDGE**

Provident was aware of TEFRA and its shift in responsibility well in advance of TEFRA's actual effective date. This awareness was far more than a casual observance of the new law. Indeed, Provident undertook actuarial research measures to accommodate the added liability TEFRA imposed. As early as late 1982, Provident acknowledged its primary liability for medical expenses of the working aged and their spouses who were covered by a Provident issued or administered EGHP. See, Exhibit "B".

In addition to notifying all group policy holders of the obligations imposed by law and the shift of responsibility for medical claims of the working aged, Provident also reevaluated its premium schedules and assessed the "working aged" insureds a surcharge for this added liability. See, Exhibit "C". After collecting a premium for the added liability imposed as a result of the enactment of TEFRA, Provident embarked on a course of conduct designed to avoid this liability and processed for payment or paid the medical expense claims of the working aged on a secondary basis instead of a primary basis as imposed by law and contract.

Provident's masterful scheme was successful because, with limited exception, if Provident's personnel followed directions, no one would catch on to what Provident was doing. One Provident

regional manager stated in internal correspondence directed to numerous high ranking Provident group department officials:

> It is quite obvious to everyone that Medicare has no way of knowing who in their claim files is an active employee...consequently, they never will be able to track this down and pass it back to the insurance industry. (Emphasis added). See, Exhibit "D".

Provident also communicated directly with Medicare administrators and confirmed that so long as Provident concealed its obligation, it wouldn't get caught. A manager of Quality Assurance and Training in one of Provident's group field offices wrote to Provident's Director of Quality Assurance and Training:

> Mr. Vickers did not want us to administer benefits as secondary since the provider would then not contact Medicare concerning overpayment of charges and other group insurance would not be discovered by them. See, Exhibit "E".

V. PROVIDENT'S COURSE OF CONDUCT

Despite Provident's knowledge of the shift in responsibility for medical claims of the working aged from Medicare to EGHP's, and Provident's knowledge and understanding of its financial obligations under TEFRA and subsequent legislation, Provident's course of conduct was designed to deliberately ignore and avoid its financial obligations. This deliberate action resulted in Provident's general business practice of abusing its position of responsibility and abusing the Medicare system. In order to facilitate the concealment of its primary coverage, Provident's objective was to make certain Medicare received and paid claims first. This way, Provident could be certain Medicare would not

discover Provident's primary coverage. To accomplish this, Provident needed only to instruct its adjusters to first determine what Medicare is doing before paying a claim.

As early as January 14, 1983, Provident knowingly chose to avoid its financial obligations and pay secondary when it was obligated to pay as primary. A group claim bulletin issued on January 14, 1983 clearly instructs Provident's claims adjusters to pay on a secondary basis even though Provident is well aware of their primary responsibility. See, Exhibit "F".

In instances where claims were sent directly to Provident first (rather than Medicare), Provident had to alter its scheme in order to conceal its coverage. Since Provident's adjusters couldn't wait on a primary Medicare payment, (Medicare hadn't received the claim yet) Provident made certain that Medicare got the claim and paid it so that Provident would not have to reveal its coverage. To accomplish this, Provident's adjusters were instructed to require proof of Medicare payments from the insured prior to paying. Provident's claim offices sent form letters to persons who submitted a claim that had not been submitted to Medicare. A form letter states, in part:

> WE ARE UNABLE TO COMPLETE THE CORRECT PROCESSING OF THIS CLAIM UNTIL WE HAVE RECEIVED A COPY OF THE EXPLANATION OF BENEFITS PAID BY MEDICARE. (Exhibit "G").

A second form letter states:

> OUR FILES INDICATE THAT THE PATIENT IS ALSO COVERED BY MEDICARE.
>
> SINCE OUR PLAN IS CONSIDERED TO BE SECONDARY CARRIER, ALL CLAIMS MUST BE FILED WITH

MEDICARE FIRST FOR BENEFIT DETERMINATION AND PAYMENT. AT THAT TIME, PLEASE SEND US A COPY OF THE PAYMENT EXPLANATION FROM MEDICARE SO THAT WE CAN CALCULATE THE CURRENT AMOUNT OF BENEFIT. (Exhibit "H").

It is abundantly clear that Provident knew precisely what was required by the Medicare Secondary Payer Program. Provident acknowledged its obligations under these laws and contracted to perform its obligations by agreeing to administer the EGHP's pursuant to applicable law. Nevertheless, Provident developed claims handling procedures to avoid its legal and contractual obligation to pay and process for payment the claims of the working aged on a primary basis. Indeed, some of Provident's employees recognized these violations and their efforts to eradicate the deceitful practices implemented by Provident were rejected. On March 5, 1985, Marilyn Shelley, a Claims Supervisor within Provident, reported to Provident's home office the fact that the claims procedures which had been implemented violated federal law. Even though such violations were reported to the home office, Provident continued to manipulate its claims handling process in order to avoid and conceal its primary obligation to pay the medical expenses of the working aged and their spouses. See, Exhibit "I". Provident's course of conduct and violations of law are reflected within Provident's handling of the claims of beneficiaries whose medical expenses were to be paid under group health plans insured and/or administered by Provident. Attached are examples of Provident's implementation of its scheme to avoid

and conceal the obligation to process for payment and pay on a primary basis. See, Exhibits "J", "K" and "L".

Circumstances involving Ms. Hildenbrand's and Ms. Duncan's claims establish that even after Provident was confronted by inquiries from the insurance commissioners and complaints from their own insureds, Provident continued to violate the law and refused to acknowledge its primary responsibility. Provident's response to such complaints resulted in the mere payment of the balance that was due to the providers. Provident intentionally failed to reimburse Medicare or issue the appropriate payment even when confronted by a complaint from insurance commissioners.

Provident compounded its fraudulent misrepresentations by engaging in a coverup designed to conceal its obligation to reimburse the government funds it was entitled to receive even though Provident's employees have admitted that it was the company's responsibility to pay the medical expenses of the working aged on a primary basis and reimburse Medicare for all Medicare overpayments. In the 1986 deposition of James Edward Mitchell, the Assistant Vice President of Field Claim Operations testified where Medicare paid as primary on claims where Provident should have paid as primary, Provident owes an obligation to come forth voluntarily and reimburse Medicare. See, Exhibit "M".

The activities designed to coverup the scheme include suggestions on the part of Provident employees that the company take a "tough stand" if Medicare ever goes back through the EGHP and seeks reimbursement for funds paid out by the Medicare

intermediary based on the false claims which were caused to be submitted by their actions or when Medicare requested the funds which rightfully belong to Medicare but were concealed through false records or statements and wrongfully retained by Provident. See, Exhibit "N". Provident's "tough stand" has also resulted in the destruction of the logs, the only easy means with which Medicare had to prove the sum of money owed by Provident.

Perhaps one of the most flagrant abuses of the Medicare system is revealed in Provident's correspondence with its customers, including the Campbell Soup Company. Correspondence exchanged between the Campbell Soup Company and Provident in June of 1983 indicates that Campbell requested Provident to develop a method in order for Campbell to reimburse Medicare when Campbell had erroneously provided benefits on a secondary rather than primary basis. In response to the customers' inquiry, Provident advised Campbell to forego any voluntary reimbursement. See, Exhibit "O". Other correspondence exchanged between Provident and its customers revealed hold harmless agreements which were entered into between Provident and employers whose plans were insured or administered by Provident. The hold harmless agreements were obtained by Provident in an effort to seek indemnity from the employer since Provident recognized that the payment of claims on a secondary basis violated federal law. See, Exhibits "P" and "Q".

IV. CONCLUSION

Provident assumed direct liability for the payment of benefits by issuing insurance policies to employers covering the medical

expense claims of the working aged and agreed with employers to administer their group health plans in accordance with applicable law. Without question Provident owed an obligation to the government to process for payment and pay the claims of the working aged on a primary basis. Provident's failure to do so has resulted in substantial losses to the government.

The Medicare system relies upon a variety of organizations and sources in order to adequately process claims. Intermediaries, providers, beneficiaries, insurers and employers are required to work together in order to implement the laws and regulations thereby yielding the intended result. A claim within the Medicare system is not simply the presentation of an invoice between two parties but requires the free exchange of information between intermediaries, providers, beneficiaries, employers and insurers so that the process can successfully accomplish its goals.

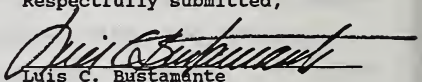
Provident with complete knowledge of: (i) the obligations imposed by law; (ii) the process implemented to pay the medical claims of Medicare beneficiaries; and (iii) the need for a free exchange of information between all interested parties, embarked upon a course of conduct designed to gain advantage of the Medicare system and avoid the payment of claims on a primary basis.

Provident has systematically drained the Medicare system by paying the claims of the working aged on a secondary basis when it should have paid or processed for payment those claims on a primary basis. The fact that Provident was able to successfully perform its scheme for numerous years through the presentation of false

statements, via beneficiaries, providers and hospitals, clearly reflects the need for the government to not only address administrative inefficiencies within the Medicare system but also seek redress from Provident for all damages caused by their outrageous conduct.

No matter how inept Provident believes the Medicare intermediaries and the Medicare system to be in failing to discover the availability of benefits under an EGHP, such ineptitude in no way grants a license to Provident, or any other insurance carrier, to take advantage of the Medicare system by avoiding and concealing its obligation to pay or process for payment the claims of the working aged on a primary basis. The losses incurred by the government do not evolve solely as a result of the failure of a particular organization to disclose information to the government but is directly as a result of the calculated actions of Provident and other carriers who have failed to pay or direct payment of claims by the working aged on a primary basis when Provident and others knew well in advance that the group health plans they insured or administered were responsible for payment on a primary basis.

Respectfully submitted,



Luis C. Bustamante

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1401 Brickell Avenue
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Miami, Florida 33131-3553

EXHIBIT LIST

A. Letter to Congressman Claude Pepper dated December 5, 1984

B. Provident Memorandum and letter to group policyholders dated November, 1982

C. Provident Memorandum re: Medicare, Tax Equity and Fiscal Responsibility Act of 1982

D. Letter from Donald F. Reardon dated September 8, 1983

E. Memorandum dated April 1, 1986 re: active employees and spouses age 65 - 69

F. Group Claim Bulletin dated January 14, 1983

G. Provident Form Letter L No. 001

H. Provident Form Letter L No. 016

I. Provident Memorandum from Marilyn Shelley dated March 5, 1985

J. Affidavit of Ana Mae Hildenbrandt and Complaint file from Department of Insurance, State of Indiana

K. Telephone sworn statement of Marie Duncan dated November 17, 1988

L. Affidavit of Hilda Thomas dated October 25, 1989

M. Deposition of Mims Edward Mitchell obtained on August 11, 1986

N. Memorandum dated November 26, 1985 from Phyllis O'Connor

O. Correspondence dated June 29, 1983 from Campbell Soup Company to Provident and response from Provident dated July 6, 1983

P. Correspondence dated April 11, 1983 from Provident

Q. Provident correspondence and agreement dated May 3, 1985

STATEMENT OF

WINSTON W. WALKER,
PRESIDENT AND CHIEF EXECUTIVE OFFICER
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

TO THE

PERMANENT SUBCOMMITTEE
ON INVESTIGATIONS
OF THE SENATE COMMITTEE
ON GOVERNMENTAL AFFAIRS

July 11, 1990

I. INTRODUCTION

My name is Winston W. Walker. I am the President and Chief Executive Officer of Provident Life and Accident Insurance Company, Chattanooga, Tennessee. I appreciate the opportunity to appear before this distinguished Subcommittee as part of your inquiry into the problems that continue to plague the Medicare program. I hope that Provident's experiences and our recommendations will assist this Subcommittee in resolving Medicare's administrative difficulties so that the private and public sectors can work together to improve the program.

Provident Life and Accident Insurance Company is among the ten largest life and health insurance companies in the United States, and plays a prominent role in the group health market. Last year we paid nearly $3 billion dollars in group health claims, representing more than 65,000 separate claim transactions per day.

I began my career at Provident 16 years ago as an actuary in the Life Department. Before coming to Provident, I was an assistant professor of mathematics at Wake Forest University and later a consultant with Book and Company in North Carolina. I received my B.A. degree in Russian language and literature from Tulane University, and a Ph.D. in mathematics from the University of Georgia. I am a Fellow in the Society of Actuaries.

Provident takes part in this discussion as an insurer or administrator of employer group health plans. We are not part of the Medicare system--we have never been a Medicare contractor--and we are not informed of Medicare's policy-making decisions about how the program is to be implemented. Neither are we, as an insurer or administrator, subject to the statutory provisions which govern the Medicare program. If we have any responsibility for claims that Medicare has paid, it is only by reason of contracts that we have with our clients, the employers who sponsor group health plans that we insure or administer. Our obligation is to fulfill our contractual responsibilities to our clients, and we take those responsibilities seriously.

II. THE HISTORY OF THE MEDICARE EXCLUSIONS

Until about ten years ago, Medicare paid benefits for individuals regardless of whether they had other sources of payment for their medical expenses. In 1980 Congress made the first in a series of changes to the Medicare program to provide that Medicare would not pay benefits for persons to the extent that coverage was available elsewhere. The first change was to exclude coverage for persons who were eligible for payment of their medical expenses through automobile or liability insurance.

Despite serious problems with implementation of this first exclusion, documented in numerous government reports, Congress the following year added another category of individuals--those with end-stage renal disease--to the list of Medicare exclusions. Medicare would no longer pay benefits for these persons for the first twelve months of treatment for end-stage renal disease, to the extent that coverage was available from the person's employer group health plan.

Again, Medicare experienced serious problems in identifying persons in this category and continued to pay benefits that it was not supposed to pay. Either unaware of or unconcerned about this fact, Congress continued to enact a series of additional amendments to exclude coverage for other categories of beneficiaries to the extent that coverage was available through their employer group health plans. These categories include the so-called "working aged" and "active disabled."

The working aged originally included only employed persons between the ages of 65 and 69 and their spouses aged 65 to 69. Congress later changed the age limit for the working aged to apply the Medicare exclusions to all actively employed persons over 65 and the over-65 spouses of actively employed persons of any age. The active disabled are persons who are eligible for Medicare because of their disability but who are still considered to be actively employed.

When Congress passed these amendments, it directed Medicare not to pay claims when other coverage was available. Congress did not direct private payers how to respond when Medicare violated its statutory duty.

III. MEDICARE'S IMPLEMENTATION PROBLEMS

A. Government Recommendations

While Congress may not have been aware of the difficulties that Medicare experienced in implementing all these exclusions, the persons responsible for administering Medicare were all too familiar with the problem. The Office of Inspector General of the Department of Health and Human Services and the United States General Accounting Office have published numerous audit reports beginning as early as 1984, documenting the administrative deficiencies that cause Medicare to pay claims that it should not pay. A list of 23 reports that we have been able to obtain is attached to this statement as Exhibit A.

There is a uniform theme that runs through all these reports. Medicare has not adopted procedures to identify beneficiaries with other coverage before it pays claims. The Inspector General and the GAO continue to make recommendations to

improve the identification process, but Medicare appears to have made little progress in implementing the recommendations.

Medicare has relied almost exclusively on health care providers to obtain information from the patient about other group health plan coverage. The providers are supposed to bill the plan before they bill Medicare. As Richard Kusserow, HHS Inspector General, reported sometime in 1984 to then-Administrator of the Health Care Financing Administration, Carolyne K. Davis,

> *Past studies have shown that millions of dollars in third party resources are lost to the Medicare program every year, much of it due to providers failing to identify third party medical insurance resources. There is no reason to believe that providers will be any more effective in identifying employer health coverage for Medicare beneficiaries. Yet, implementation of the "working aged" provisions rests mainly with these providers.*

At that time the Inspector General recommended that Medicare contractors establish "front-end controls" designed to identify beneficiaries with other coverage and to suspend claims automatically prior to payment to verify the existence of other coverage. In subsequent reports, the Inspector General continued to criticize Medicare's failure to identify beneficiaries before claims are paid. Nevertheless, as recently as 1989, Louis B. Hayes, then acting Administrator of HCFA, acknowledged to Mr. Kusserow that Medicare continues to rely on largely ineffectual "beneficiary self-identification" through health care providers.

Self-identification can work; it is how insurers, who effectively coordinate benefits with other insurers, discover whether plan beneficiaries have other coverage. Medicare's problem is that the providers have not done an adequate job of obtaining the necessary information, and Medicare has not forced them to do so.

B. Private Sector Recommendations

It was no secret outside the Medicare establishment that problems continued unabated. One of Provident's major customers, after learning of Medicare's payment problems from a Provident employee, complained in 1985 to his senator, Mr. Strom Thurmond, that HCFA continued to pay claims that it should not pay. In response, HCFA assured the Senator that they were working on the problem and that Medicare

had matters under control. This series of correspondence is attached as Exhibit B. In retrospect, HCFA's assurances were obviously premature.

Throughout 1984 and 1985, Provident's industry association, the Health Insurance Association of America, together with the Blue Cross Blue Shield Association, met on numerous occasions with representatives of HCFA in attempts to devise means by which Medicare could identify claims before they were paid. The industry proposed a system by which employers would certify to HCFA the names and social security numbers of Medicare-eligible persons covered under their group health plans. Attached to this statement as Exhibit C is correspondence with HCFA detailing the industry's proposal. HCFA did nothing to implement this proposal.

C. HCFA's Failure to Respond

The industry's recommendation was similar in concept to a proposal made by the HHS Office of Inspector General about the same time. The Inspector General proposed to identify beneficiaries who have group health plan coverage by exchanging data already available to Medicare through the Social Security Administration. HCFA did not adopt this recommendation. It was not until after Medicare's failings became the subject of unfavorable publicity in 1989 that HCFA requested authorization to perform data matches with other Government agencies. The Omnibus Budget Reconciliation Act of 1989 authorizes HCFA to obtain previously inaccessible data from the Internal Revenue Service, in addition to Social Security information, and to perform data matches with records already in the Government's possession.

While Medicare struggled with its administrative problems, at the same time that it refused to accept the recommendations either of its Inspector General or of the insurance industry, it left private payers in the dark. Medicare knew that it continued to pay claims that should have been directed to other payers, but did not tell the payers--automobile or liability insurers, employers and their plan insurers and administrators--how they should respond to claims that Medicare had already paid.

IV. ALTERNATIVE RESPONSES TO MEDICARE'S MISTAKES

There are several ways in which Provident or any other insurer or administrator of group health plans could respond to Medicare's mistakes. Without further guidance, each of them creates its own problems.

Provident has no vested interest in selecting one method over another. It did not stand to profit from the way it paid claims that were already paid by Medicare. For most claim payments, Provident is only a claims processor for the plan; it pays group health benefits not with its own money, but with the plan's money. Even where Provident insures the plan, the insurance agreement may provide that Provident will refund money to the plan if the premiums are more than the amount of claims that Provident paid on the plan's behalf.

More complete explanations of the basic types of arrangements that Provident has with group health plans, and why Provident does not profit from the way it pays claims that Medicare already paid, are described in the affidavit of a Provident employee, Stephen T. Carter, attached as Exhibit D.

A. Pay Duplicate Benefits

In many instances both Medicare and an employer group health plan paid benefits to health care providers or to plan beneficiaries. Medicare would pay benefits without first determining that the provider or beneficiary was entitled to them. Medicare apparently expected that private payers would also pay the provider or beneficiary (but did not inform them that this was how they were expected to respond). Medicare would then depend on the recipient to volunteer to repay Medicare the amount that the recipient had been overpaid.

This was not very smart. Surely it was not Congress's intention to double the cost of health care in this country by having Medicare and private payers make duplicate payments to health care providers or Medicare beneficiaries. Could health care providers or beneficiaries be counted on to repay duplicate benefits? Apparently not. A 1985 report by the Inspector General estimated that over $200 million in Medicare overpayments was being held in hospital credit balances. OPI-85-7-040, attached as Exhibit E; see A-10-86-62003, attached as Exhibit F (duplicate payments not refunded to Medicare).

To Provident's knowledge no study has been done on the amount or disposition of duplicate payments made directly to Medicare beneficiaries. It is not unreasonable to suppose that because of Medicare's complexity many beneficiaries are not aware that they may have received overpayments. Even if they are, Provident does not know of any incentives for beneficiaries to repay Medicare voluntarily.

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Making duplicate payments is also more confusing to the beneficiary, who must contend not only with the ordinary complexities of Medicare but with the additional problems associated with untangling the payments and trying to determine who should repay whom and how much. One of Provident's clients wrestled with Medicare for months in late 1987 and early 1988 after telling health care providers and Medicare that a beneficiary under the plan was "working aged." Medicare continued to pay claims that Provident also paid, resulting in increased confusion, frustration and administrative headaches for the plan. See Exhibit G.

B. Pay Medicare on Request

An alternative is for private payers to pay Medicare on request. This alternative has the advantage of protecting elderly or disabled beneficiaries from being badgered by HCFA for refunds of duplicate payments.

Provident was accustomed to payment requests from Medicaid, another federally-funded health care program also under HCFA's jurisdiction (although partly funded and administered by the states). An example of how one state's Medicaid program, the "Medi-Cal" program in California, sought recovery from private payers is attached as Exhibit H. Provident had every expectation that the Medicare program would develop similar recovery procedures, and always intended to honor Medicare's valid requests for payment.

Based on the Government's current litigation posture, Medicare is not in favor of this alternative. In fact, HCFA has instructed its contractors not to request payment from Provident. See Exhibit I. Medicare's basic failure to identify beneficiaries properly apparently means that--unlike Medicaid--it cannot figure out when to make such a request, to whom, or for how much.

C. Pay Medicare Directly

A third alternative may be for private payers to pay funds directly to Medicare. There are no assurances, however, that Medicare would accept the funds. As recently as December 1987 a Medicare contractor refused to accept a check from Provident for a claim that Medicare paid by mistake. Exhibit G; see also Exhibit F ("unresolved systems problem" prevented Medicare intermediary from accepting recoveries from hospital that had received duplicate payments). In addition, no procedures exist to instruct private payers to make payments directly to Medicare, to tell them how to do it, or to give them credit if they do. On the contrary,

Provident has on occasion been informed that Medicare deals with the health care providers on overpayment issues and that we should not be concerned about them.

It was not until November 13, 1989, the effective date of new regulations, that HCFA suggested that private payers should bring Medicare's mistakes to Medicare's attention. Under the new regulations, if private payers do not bring the mistake to the attention of the right person at the right time, Medicare can try to extract another payment from the private payer in the event that Medicare cannot recover its mistaken payment from the recipient. The regulations do not include procedures for private payers to use in notifying Medicare, and HCFA staff have admitted that the regulations are inadequate to protect private payers from the possibility of having to pay twice. This provision of the regulations may also exceed HCFA's authority, and is the subject of legal challenges by the Health Insurance Association of America and the Blue Cross Blue Shield Association.

Provident has paid duplicate benefits, it has paid Medicare on request, it has even attempted to make unsolicited payments directly to Medicare. None of it has made any difference. Provident or another insurance company would still be here today with the same story of Medicare's failures, no matter how it responded to Medicare's mistakes. The truth is that Medicare cannot tell this Subcommittee who did what, when, why, or on whose behalf, how much it cost Medicare, whether Medicare can recover its payments, or from whom, because it never established effective procedures to identify beneficiaries who have other coverage.

V. "WHAT WE HAVE HERE IS A FAILURE TO COMMUNICATE"

A. Medicare's Refusal to Communicate with Private Payers

The most distressing aspect of reviewing these alternatives is that they demonstrate Medicare's total lack of interest in enlisting the support of private payers to make the program work. Even now, Provident's claims adjusters cannot get information from Medicare to assist in the payment of claims. One of Provident's largest clients, Hercules Incorporated, of Wilmington, Delaware, in an unsolicited letter of support for Provident, recently voiced its frustrations with Medicare. Mr. Patrick C. Donahue, Manager of Welfare Plans at Hercules, said in a letter to me last month that:

> *The number 1 communication problem we face at Hercules is trying to explain to our pensioners why Medicare did what it did with their medical claims. The problem for us is we cannot figure out what they did, or why. Referrals to the local Social Security offices are fruitless. Calls to the fiscal intermediaries are a true waste of time.*

A copy of Mr. Donahue's letter is attached as Exhibit J.

Medicare personnel do not care to bring private industry into the loop. We have never been given a reason to believe that anyone at HCFA or its contractors had the slightest interest in what we did. There are no lines of communication, no points of contact; more important, there is no encouragement to participate in a process that has no place for us.

Yet one of the reasons Provident is here before you today is because there are some within the Government who think that Provident and other insurance companies are central to the success of this program. If this is true, Provident respectfully inquires why Medicare has ignored the private industry over the past ten years.

Why has Medicare disregarded the industry's recommendations for identifying beneficiaries who have other coverage?

Why has Medicare refused to admit publicly the scope of its administrative problems and seek the industry's assistance?

Why has Medicare failed to instruct the industry in preferred ways of responding to Medicare's initial mistakes?

Why do Medicare contractors have no written instructions for us when we ask what we should do about their mistaken payments?

Why, after all these years, has the Government broken its official silence, not to enlist the aid of private payers but to excoriate them for mistakes that Medicare made?

Why, when the Medicare exclusions unequivocally direct Medicare not to pay claims, are private payers being targeted as villains because Medicare violated its own statutes?

Why are Provident and other private insurers publicly accused of failing to meet responsibilities that have never been imposed on them?

Why has the government chosen a hostile, adversarial approach to the private industry rather than seeking to enhance cooperation and communication, two elements that are absolutely essential to the success of the program?

B. How Communication Makes Coordination of Benefits Work in the Private Sector

The private insurance industry has been coordinating benefits successfully for many years. There is no mystery to the process. Insurers elicit information about other coverage on the claim form. If this information is not provided, companies that are serious about coordinating benefits will not pay the claim. If the information is provided, the insurers will talk to each other to determine which company pays first, which pays second, and how much each should pay.

Insurers operate according to uniform guidelines adopted almost 40 years ago by the National Association of Insurance Commissioners. A copy of the current version of the guidelines is attached as Exhibit K. All companies understand what they are supposed to do because the guidelines are available to them in writing, and always have been.

VI. "PAY AND CHASE" WAS A BAD CHOICE

Contrast this operation with Medicare. Medicare does not adequately elicit information about other coverage. If the beneficiary does not provide information about other coverage, Medicare merely assumes that it should pay, and does pay, even when it should not. As recently as March of this year the Inspector General found it necessary to recommend to HCFA that Medicare claim forms require an answer to the question "Do you have health insurance as a result of your, or your spouse's, current employment?", and that the contractors suspend claims until the question is answered. A-09-89-00100 at 7, attached as Exhibit L.

A. Inadequate Claim Forms

Three separate forms are used for submitting claims to Medicare: (a) the hospital claim form, HCFA-1450 (UB-82); (b) the physician claim form, HCFA-1500; and (c) the forms that beneficiaries use to submit claims directly to Medicare, HCFA-1490-S. Copies of each are attached as Exhibit M.

(a) The hospital form has not been altered to record specific information on the availability of group health plan coverage. Instead, hospitals are supposed to list the identity of other payers in order of priority. If the hospitals do not make proper inquiries, they do not have a basis for listing the payers in the correct order. Because the form does not record details about other coverage, Medicare contractors do not know whether the hospitals asked the right questions or properly interpreted the responses. In Provident's experience, hospitals frequently list Medicare first, even though coverage is available to the beneficiary from a group health plan that should be listed first.

(b) The physician form contains a small block to be checked if "insured is employed and covered by employer health plan." This block does not ask all the right questions; for example, it does not ask whether the employed person's spouse is covered by a plan. If the block is not checked, Medicare has no way of knowing whether this was inadvertent or whether it was because there was no other coverage. Medicare apparently assumes the latter, and pays claims that are submitted without information on other coverage even though other coverage is available.

(c) The beneficiary claim form asks the patient about employment and employee benefit coverage both through the patient's own employment and the spouse's employment. This form also requests a "yes" or "no" answer. While not perfect, this is the most complete form of the three. Unfortunately, direct claims from beneficiaries probably represent a very small proportion of Medicare payments.

In any event, asking the right questions does not help if Medicare does not require an answer before the claim is paid. Given Medicare's penchant for paying claims even when claim forms are either incomplete or incorrect, the positive effect of these questions is severely limited.

B. Political Appeasement

Medicare's current practice of paying claims without adequate documentation is apparently a political decision to avoid controversies with health care providers and beneficiaries over delayed claim payments. The American Medical Association, for example, has complained to HCFA that

> *. . . through no fault of their own, physicians are being denied payment in cases where the [Medicare] carrier is determining 'secondary payor status'. . . . Instead of placing the innocent physician at risk, Medicare should pay the claim (subject to all usual reviews for necessity and coverage). Then, if Medicare proves to be secondary, the carrier should process a claim against the party with primary coverage.*

Exhibit N. According to the AMA, HCFA agreed and instructed Medicare carriers not to suspend claims even though neither the physicians nor the beneficiaries had demonstrated their entitlement to payment from Medicare on those claims. Id.

C. Medicare Was Not Interested

Medicare has exhibited no interest in discussing claims with other sources of coverage. It is our experience that Medicare claim adjusters will not share information about claim payments where Medicare has already paid the claim and Provident is trying to clarify how much of its claim payment might be subject to Medicare's recovery procedures.

If Medicare has uniform procedures that it wishes private payers to follow, it has not seen fit to let the private payers in on the secret. To our knowledge, Medicare does not yet have written procedures to instruct other payers how to deal with payments that Medicare made by mistake. As recently as 1988, in response to specific requests, Medicare contractors routinely told Provident adjusters that no written procedures were available.

The keys to success in coordinating benefits, whether it is between two private insurers or between Medicare and a group health plan, are communication and cooperation. Medicare will not communicate with private payers and will not even acknowledge that there may be opportunities for cooperation. Instead, Medicare spent years in an ill-advised campaign of "pay and chase"--just pay the

claims so the hospitals and doctors and beneficiaries do not complain, then hope that later on you can chase down a source of recovery.

D. Paying the Price for "Pay and Chase"

Medicare's solution in 1989: Let someone else pay for Medicare's mistakes, not just by paying the benefits that Medicare paid by mistake, but much more important by thrusting on private industry the substantial administrative costs involved in trying to salvage a program that Medicare botched. Medicare is not placing this responsibility on those who are a part of and profit from the Medicare system--hospitals, doctors, beneficiaries, intermediaries and carriers--but on persons outside the system who have no control over what the insiders do.

Medicare's current strategy is to sue private payers, demanding that they search nine years of claims files to find the errors that Medicare made. Even if this can be done, which is doubtful, it is infinitely more difficult and costly for everyone to try to reconstruct years of payments than it would have been for Medicare to deal with private payers as the claims occurred.

Policymakers at the highest levels of government, both in the Executive and the Legislative branches, failed to give Medicare the resources it needed to implement the payment exclusions properly. They made expedient policy decisions to pay claims without sufficient documentation to avoid complaints from providers and beneficiaries who could not get their money fast enough. These same policymakers are now punishing private payers--entities that are completely outside the Medicare system and who do not receive payments from Medicare--by coercing them, through so-called "program audits" or through discovery in litigation, to do the job that Medicare should have done.

VII. PROVIDENT'S EXPERIENCE

Paying billions of dollars in claims every year is an enormous job, and Provident takes pride in doing it well. Government does not make our task easy, however. One of the most challenging aspects of our business is ensuring compliance with hundreds of changes in group health insurance or employee benefit plan laws and regulations every year.

A. Coping with Legislative and Regulatory Initiatives

As an insurance company, Provident is subject to regulation by all the states in which it does business. Each year, the states pass hundreds of new laws, and adopt regulations, that affect group health insurance policies. It is a constant effort to keep up with the new laws and regulations that affect our business.

In recent years Congress has entered the fray with continual changes in laws governing our clients--employers and their employee benefit plans. These laws are often complex yet vague, requiring substantial agency interpretation through the adoption of regulations. The regulations are seldom adopted in time, so that these very important and complex laws go into effect with no guidance given to those who must comply. Our clients may be subject to stiff penalties for failure to comply with laws that no one understands. Internal Revenue Code Section 89 on non-discrimination in benefit plans is perhaps the most notorious example of this unfortunate trend, but it is by no means the only one.

B. The Need for Regulatory Guidelines

The story of the Medicare exclusions and their consequences for private industry is becoming all too familiar. Provident, and I believe the rest of the private insurance industry, is eager to meet its legal and regulatory obligations. We are just as eager to see that we do our best on behalf of the employers and group health plans with which we do business. We are in the service business, and part of providing good service is helping our customers comply with the laws that apply to them. But what is the law?

We are forced to operate in a kind of limbo for years while government agencies try to interpret the practical consequences of a law or, in this instance, while they try to implement the necessary administrative changes to comply with the law themselves. Passage of a law is only the beginning of a routine of temporary guidelines, revised regulations, revisions to revisions, and so on year after year until final regulations are eventually issued. In the case of the Medicare exclusions, regulations proposed in 1988 and made effective in late 1989, nearly seven years after the effective date of the "working aged" law, are radically different from either the law itself or the regulations that were adopted in the months after the law was enacted.

Through all this, we must try to serve the needs of our customers, protect the Company's interests, and be prepared to change--perhaps even reverse--our practices according to the latest set of guidelines. Apparently government agencies believe it is legitimate to place us at risk if we do not predict accurately their eventual decisions on what the law means.

C. The Bleeding Continues

It is scandalous that Medicare's claim payment problems could have existed for so long, well documented and well known, without the government making any effort to enlist the aid of the private sector. It is even more appalling that when Medicare's failures were about to be publicized outside the Government its reaction has been to blame the private sector and attempt to exonerate itself. Provident, for one, does not intend to let Medicare off the hook so easily.

Medicare continues to pay medical bills that should have been submitted first to employer group health plans. Neither Medicare's administrators nor its contractors have made the necessary effort to determine in the first instance whether or not payment can be made by an employer group health plan. Instead,

1) Doctors, hospitals and Medicare beneficiaries send their bills to Medicare first, even when other coverage is available.

2) Medicare contractors pay the bills that have been sent to them, even when other coverage is available.

Provident has no part in these transactions. They occur because of decisions made by beneficiaries, doctors, hospitals and Medicare contractors before Provident, or an employer group health plan insured or administered by Provident, enters the picture. Nothing that Provident does, or fails to do, has any effect on these decisions.

Attached as Exhibit O are charts that illustrate the flow of claims from providers to Medicare, and the mistakes they all must make, before Provident first sees the problem claim. The charts demonstrate that Provident does not cause Medicare to pay claims by mistake; Medicare (with a little help from providers and beneficiaries) manages to do that all by itself.

D. Provident's Dilemma

After Medicare has paid a claim that it should not have paid, Provident may receive a claim from the doctor, hospital or beneficiary for the balance that Medicare has not paid. By then Medicare has already caused the damage. Provident is willing to do its part to try to repair the damage created by a series of mistakes previously made by others, but no one has yet enlisted Provident in this effort.

To this day, there is no written guideline that tells Provident how it should pay claims that Medicare has already paid. There is no law, regulation, manual provision, letter, guideline or other written determination on which Provident can rely that requires Provident, on behalf of employer group health plans, to choose one method of responding over another.

Certain government agents apparently believe that Provident, on its own initiative, should have implemented a voluntary, unilateral procedure by which it would have forced Medicare contractors to accept payments from Provident. Never mind that neither the law nor Provident's contracts with employer group health plans authorize Provident to pay benefits to Medicare instead of to the plan beneficiary (or, if the beneficiary directs, to the health care provider); disregard the fact that Medicare's systems would not even accept payments from private payers. Since Provident did not implement such a "voluntary" procedure, Provident is alleged to have violated the Medicare laws.

1. The Need for Declaratory Relief

Provident should not have to point out the absurdity of claiming that failure to adopt a voluntary position has the same legal effect as though it were failure to comply with a statutory mandate, but apparently we must. Provident was forced to seek a ruling from the United States District Court for the Eastern District of Tennessee on its rights and obligations under the law. In a highly unusual, but revealing, move, the Government also asked the Court for a declaratory ruling on what the law means.

The Court recently adopted Provident's interpretation of the law, and rejected the Government's position, in two major respects. What the Court has not yet done (and may never do) is to direct the Government to establish rational, consistent procedures that Provident and others can follow when Medicare makes a mistake.

Various governmental representatives, or persons claiming to speak on behalf of the Government, have informally made contradictory suggestions as to how Provident should pay claims that Medicare has already paid. If Provident does what one group says it must do, it risks being penalized in one way or another. Provident's dilemma has been described in detail in pleadings it has filed with the Tennessee court. In order to protect itself, Provident has begun paying disputed amounts into an escrow account approved by the court.

2. Establishing an Escrow Account

In a nine-month period ending April 30, 1990, Provident paid more than $578,000 into the escrow account. This represents an average of over $60,000 a month in claims that Medicare contractors continue to pay despite the exclusions in the Medicare laws. Nine years after the effective date of the end-stage renal disease provisions, seven years after the effective date of the "working aged" provisions, and three years after the effective date of the "active disabled" provisions, Medicare contractors still pay claims that they are not supposed to pay.

VIII. SUGGESTIONS FOR IMPROVEMENT

Provident's suggestions for how to improve Medicare's performance are three-fold: (a) Medicare must fix the system up front; (b) Medicare should think first and pay properly; and (c) Medicare must talk to private payers about the claims that are misdirected to Medicare.

A. Fix it Up Front

Medicare must instruct hospitals, doctors, and beneficiaries in the correct processing of claims and enforce those procedures. Hospitals and doctors in particular should be aware that they may be able to collect more from private insurers if they bill them properly than they would be able to collect from Medicare. Not only are hospitals and doctors legally obligated to bill properly, it is in their financial interests to do so.

This recommendation is consistent with recommendations made by the Inspector General and the GAO for years:

- train hospitals and doctors regarding systematic admissions procedures and the processing of claims. (July 1986, January 1987, January 1988, February 1988)

- require hospitals to use a standardized admission form on which beneficiaries must report group health plan coverage. (January 1987, January 1988, February 1988, April 1988, March 1990)

- impose sanctions upon hospitals that consistently fail to follow claim guidelines, fail to identify beneficiaries with group health plan coverage, or retain credit balances. (November 1985, January 1988, February 1988)

- require beneficiaries to disclose other health insurance coverage to Medicare. (March 1990)

- require hospitals to use a standardized admission form on which beneficiaries must report group health plan coverage. (January 1988, February 1988, April 1988, March 1990)

See Exhibit P for a list of Inspector General and GAO Reports containing these and other recommendations.

These recommendations should have been implemented years ago; there should be no further delay.

B. Think First, Pay Properly

Medicare should absolutely prohibit the payment of claims unless they are accompanied by proof that Medicare is the proper payer. Again, this recommendation coincides with recommendations of the Inspector General over the past several years to improve the claims processing and internal procedures of Medicare contractors:

- prohibit Medicare contractors from paying claims without documentation verifying that Medicare is the proper payer. (March 1990)

- require Medicare contractors to cross-reference beneficiary accounts to identify claims. (January 1988)

- develop practical procedures for Medicare contractors to obtain beneficiary information from the Social Security Administration. (January 1988, March 1990)

It is inexcusable that after so many years Medicare continues to pay claims without adequate verification. The Medicare laws direct Medicare not to pay claims payable under group health plans; it is incumbent on the agency responsible for administering Medicare to see that this directive is obeyed. Let Medicare take some heat from the people who are asking for the money; if the providers and beneficiaries do not want to provide minimal information to document a claim properly, they should not be paid. Medicare should not reward their inefficiency or their reluctance to obey the rules by paying them anyway, and then punish the bystanders--employer group health plans--by making them pay the price of Medicare's political decisions.

C. Talk to Us

Provident recognizes that even under improved Medicare administration some claims may be filed with a group health plan along with evidence that Medicare had already paid. In those cases, employer group health plans and their insurers and administrators could be of immense help to Medicare. Medicare must cooperate, however, by articulating sound, reasonable, consistent, uniform, and reliable procedures that employer group plans can follow to accommodate Medicare's needs while protecting the plans from unfair double liability.

Provident has no vested interest in how its claims adjusters handle claims that have already been paid by Medicare, as long as the method is consistent with Provident's obligations under state insurance law, with its fiduciary obligations under the Employee Retirement Income Security Act, and with sound business practices. When the proper guidance from Medicare is in place, Provident will follow it. This is all that Provident ever wanted to do, but could not because Medicare apparently did not know, and still does not know, how it wishes the system to operate.

IX. CONCLUSION

Provident is in the business of paying claims on behalf of group health plans. Its objective is to pay claims promptly, accurately, and in compliance with all applicable laws. If Medicare believes that Provident, on behalf of a group health plan, should pay Medicare for a claim that Medicare paid improperly, all it has to do

is ask. If the claim is valid under the terms of the plan and Provident's contract with the plan, Provident will pay it. Provident has always taken this position, and always will. To the best of my knowledge, Provident has paid every valid claim that Medicare has submitted, and Medicare has never said otherwise.

Provident enters the picture after the system has already failed in at least two places, both when providers or beneficiaries improperly submit bills to Medicare and when Medicare improperly pays them. The system fails a third time, when Medicare refuses to communicate with employers and their plan insurers or administrators to guide them in responding to the two prior mistakes.

Provident did not cause this breakdown, and Provident cannot fix it. Only the Government can fix it, and then only by implementing rational administrative procedures for providers, beneficiaries and contractors and by giving sensible, consistent instructions to employers for responding to claims that Medicare already paid.

We welcome guidance from the agencies responsible for implementing the laws that affect us. We must have that guidance in order to do our jobs well. Neither the Congress nor the administrative agencies have provided the guidance we need. Please--help us help you. Bring us into the discussions; let us offer our solutions. If you do not accept our recommendations, at least let us know how to respond to the problems that you know continue to exist.

An edict from Medicare is not the answer. The program is too complex to admit of a single, inflexible solution. Many different claim situations arise that require special attention--questions need to be answered, ambiguities resolved, and procedures clarified. The most important step that Medicare could take would be to open up lines of communication with the employee benefit community to enable us to work together to achieve our mutual goals.

Insurance companies have a long and successful history of coordinating benefits among group health plans. It is due in large part to uniform procedures, clearly understood by all those who must follow them, and facilitated by a spirit of cooperation and open communication among insurers. Medicare must adopt a similar posture if it hopes to succeed with its program.

Trying to cover up Medicare's failings and shift the blame to persons who are not the cause of the problem is not only unfair, it is counterproductive. Only by focusing on the real causes and by enlisting the support and cooperation of all interested parties can we get this program on track.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

GAIL R. WILENSKY, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

JULY 12, 1990

Mr. Chairman and Members of the Subcommittee. I am pleased to have this opportunity to discuss the Health Care Financing Administration's (HCFA) activities regarding the Medicare secondary payer program.

Secretary Sullivan and I are committed to ensuring that the Medicare program does not pay for services for which private health insurers and other entities are liable. This is a goal that has been and will continue to be, at the top of the Department's agenda. Our efforts will be enhanced by recently enacted provisions that will assist us in the identification of Medicare secondary payer cases.

Background

The Medicare program, by law, cannot pay for services in certain situations when there is alternate insurance coverage. Medicare is secondary payer to an employer group health plan for certain elderly beneficiaries, for certain disabled beneficiaries, and for beneficiaries during the first 12 months of Medicare entitlement because of end-stage renal disease. Medicare is also secondary payer to workmen's compensation and to automobile, liability, and no-fault insurances. This means that the other insurance plan pays first. Medicare will pay only for covered services not paid for by the other, primary insurance plan.

HCFA has devoted significant effort and resources in the last several years to strengthen the enforcement of the secondary

payer provisions, and has achieved substantial savings for the Medicare program. In FY 1989, our secondary payer activities resulted in approximately $2.2 billion in savings through avoided expenditures, and we expect to save a comparable amount in FY 1990.

The Federal Role

HCFA has three primary responsibilities in administering the Medicare secondary payer program:

- To publish regulations, and issue policy and operational guidelines to implement the laws;
- To inform employers, insurers and providers of their responsibilities under the law. We must also inform beneficiaries of their rights under the law; and
- To identify situations where Medicare is the secondary payer and process claims accordingly.

Let me briefly describe our activities in each of these areas.

Administration of the Secondary Payer Program

Regulations - In 1989, we updated our secondary payer regulations by publishing a comprehensive rule incorporating all Medicare secondary payer requirements, except those regarding disability.

A proposed rule addressing the disabled was issued on March 8, 1990, and is now being prepared for publication in final form.

Informing and Educating - We believe that educating those parties with potential involvement in secondary payer situations is essential to assuring the success of the Medicare secondary payer program. Over the last three years, we have pursued an extensive educational campaign. We have mailed educational packages describing the MSP program to all State insurance commissioners, to insurers, to employer groups, and to over 500,000 physicians and their staff nationwide.

HCFA also developed a series of radio and television public service announcements designed to make Medicare beneficiaries aware of the Medicare secondary payer program. They were broadcast in the 31 largest television markets in 1988 and 1989.

In addition, over 5,200 presentation were made before groups representing beneficiaries, providers, physicians, employers, insurers, and third party administrators.

Identification of MSP Cases

The Medicare secondary payer program is implemented through the contractor claims payment process. The contractors rely on beneficiaries and providers to identify and bill other primary payers of health care when Medicare is the secondary payer.

However, this does not always occur. Consequently, contractors use several methods to identify secondary payer situations and avoid mistaken Medicare payments.

Contractors collect information about potential primary insurance coverage when they receive the first Medicare claim from an elderly beneficiary. If the necessary information is not clearly provided on the claim form, contractors send a questionnaire to the beneficiary asking about other insurance coverage, work status, and spousal work status. This information becomes a part of the contractor control system to identify future claims where Medicare may be the secondary payer.

The contractors review all claims involving trauma which may have resulted from an automobile or work-related accident. They also compare current claims to past claims to identify possible alternative coverage. Some contractors review their private insurance records to determine whether a Medicare beneficiary is covered under an employer group health plan.

Contractors also conduct an agressive, systematic program to recover mistaken payments when they identify that Medicare is secondary subsequent to having paid a claim. Recovery is sought from either the insurance company or the provider.

Contractors share their secondary payer information with other

contractors. This information is automated, and all contractors have access to regional secondary payer information through regional data bases. The regional data bases will be integrated into the common working file in early FY 1991. The common working file is a national, unified system of beneficiary entitlement and utilization data obtained from claims. As part of the common working file, detailed secondary payer information can be updated daily and will be available on-line to individual contractors.

Monitoring Program Implementation and Savings

We are aware of the heightened interest in the contractors' ability to ensure the accuracy of Medicare program payments in secondary payer situations. To improve the effectiveness of the secondary payer program, we have set secondary payer savings goals for the contractors. These goals are individually determined using State-specific data, actuarial projections, and statistics and other information available to HCFA. A contractor must achieve 95 percent of the targeted MSP goal to mmet HCFA's performance standards.

We believe that these MSP activities serve as effective safeguards. However, we know more needs to be done to ensure that Medicare dollars are expended only in the absence of other primary insurance.

OBRA 1989 Secondary Payer Identification Provisions

We are moving rapidly to implement the secondary payer provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). These provisions will greatly strengthen our ability to identify secondary payer situations. In particular, these provisions will assist HCFA in identifying beneficiaries with health coverage through their working spouse's employer group health plan. To date, this category of beneficiaries with primary health coverage has been difficult to detect. We believe that these beneficiaries represent the largest category of undiscovered secondary payer savings.

The OBRA 89 legislation mandates a data match among the Internal Revenue Service (IRS), the Social Security Administration (SSA), and HCFA. The steps that will occur are as follows:

- SSA will provide the IRS with the names and social security numbers of all Medicare beneficiaries for 1987 through 1989.

- The IRS will provide SSA with a file of all Medicare beneficiaries and their spouses who filed joint tax returns.

- SSA will cross-match the IRS file against its Master Earnings File to determine whether a W-2 had been filed for the beneficiary or the beneficiary's spouse.

- SSA will provide HCFA with the names and social security numbers of Medicare beneficiaries and their spouses and, if a W-2 was filed, the name of the individual's employer.

- A designated Medicare contractor will contact employers to determine whether an individual had employer health coverage.

- HCFA will use the employer information to check paid claims for mistaken Medicare payments. When mistaken payments are identified, the Medicare contractors will be instructed to recover payments.

Clearly, implementing the data match provision is a lengthy and complex activity. Let me highlight our progress to date.

- The Computer Matching Agreement required under the Computer Matching and Privacy Act has been approved by the Data Integrity Board of the Department of Treasury and will soon be submitted to the Department of Health and Human Services' Board.

- An employer questionnaire necessary to obtain information on the insured status of elderly employees and spouses is being reviewed by the Office of Management and Budget, as required by the Paperwork Reduction Act.

- A contractor will be designated by the end of this month to work with employers.

- A pamphlet is being prepared for distribution to employers describing current secondary payer provisions and employer responsibilities. The pamphlet also discusses the data match project, noting the employers' obligations and potential civil money penalties for not responding promptly.

- Employers will receive the questionnaires beginning this Fall. The designated contractor will be identified and an "800" phone number will be provided to contact the contractor. Employers may also contact local contractors or regional offices with questions.

We expect to begin processing recovery actions based on the data match project in early 1991.

OBRA 89 provides severe penalties for insurers and other entities which fail to comply with the secondary payer provisions. The Government can take legal action to collect double damages from plans that fail to make required primary payments. The law also imposes an excise tax on employers and employee organizations that contribute to a plan which does not comply. The amount of the tax is 25 percent of the total contributions to all group health plans during the year. We are now developing procedures

for the referral of non-complying group health plans to the IRS.

Enforcement and Litigation

Our efforts to recover mistaken payments represents important aspect of the secondary payer program. Medicare contractors attempt to recover mistaken Medicare payments as soon as they are identified. If unsuccessful, the contractor refers the case to HCFA. If we find evidence of intentional noncompliance with the MSP provision, we refer the case to the Department's Office of General Counsel.

In coordination with the Office of the Inspector General, our General Counsel will review the case for legal sufficiency, and refer it to the Department of Justice. If Justice concurs that legal action is warranted, it will file suit to recover mistaken primary payments that should have been paid by other entities.

Justice has filed lawsuits against three insurance companies for violations of the MSP provisions.

Blue Cross/Blue Shield of Michigan - In the lawsuit against Blue Cross and Blue Shield of Michigan, the Court ruled that the Government has the statutory right to recover Medicare payments made for beneficiaries covered under employer group health plans insured by Blue Cross/Blue Shield. However, the Court also ruled that this right does not extend to situations where Blue Cross is

acting merely as the administrator, or payment processor, for a self-insured employer group health plan. The opinion of the Judge was that the self-insured plan, and not the entity who undertakes the processing of claims, would be responsible.

We are now in the process of determining the amount that Medicare will recover. We have developed an audit protocol which the Department of Justice has referred to Blue Cross and Blue Shield of Michigan for review.

Provident Life and Accident - In the suit against Provident Life and Accident, the Court also ruled in the Government's favor to permit collection of improper payments except when Provident was acting soley as an administrator. The Court ordered Provident to provide HCFA with a list of employer group health insurance plans and beneficiaries subject to the secondary payer provision.

Travelers Insurance Company - The Department of Justice has also filed suit against Travelers Insurance Company. In December 1989, the Government asked the Court for a partial summary judgment to hold Travelers liable for all mistaken Medicare payments. The Court will not make a decision until Travelers completes discovery and submits a responsive brief.

We will continue to examine the potential for additional cases against other insurers and responsible entities.

HIAA and BC/BSA Suits - In addition to these three "offensive" cases, we are also the defendant in separate suits filed by the Health Insurance Association of America and the Blue Cross/Blue Shield Association. These suits challenge long-standing secondary payer policies that were incorporated into our comprehensive regulation. Four major policies are at issue: whether contract law supersedes Federal law; the liability of third party administrators and of insurers who underwrite employer group health plans; reporting of mistaken Medicare primary payments by insurers and third party administrators; and recovering duplicate payment from insurers and third party administrators. The Government believes it will prevail on the merits of the issues.

Conclusion

We believe we have an effective secondary payer program, as the $2.2 billion savings demonstrate. I can assure you, however, that we are not satisfied.

With the new data match authority, we believe we will be able to improve our secondary payer performance substantially and recover a large portion of payments we cannot now identify. We will also continue to investigate alternative methods to improve the identification of possible secondary payer situations.

I am confident that our secondary payer activities will continue

to make a significant contribution in savings to the Medicare program.

I will be happy to answer any questions that you may have.

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD OF MARYLAND

ON

THE MEDICARE SECONDARY PAYER (MSP) PROGRAM

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

BY

JILL JACOBY

MANAGER, MEDICARE SECONDARY PAYER UNIT

BLUE CROSS AND BLUE SHIELD OF MARYLAND

JULY 12, 1990

Mr. Chairman and members of the subcommittee, I am Jill Jacoby, Manager of the Medicare Secondary Payer Unit for Blue Cross and Blue Shield of Maryland. With me today are Susan Howell, Supervisor of the Part A Medicare Secondary Payer Unit, and Charles Best, Medicare Secondary Payer Senior Investigator. We thank you for the opportunity to discuss our role as a Medicare contractor and our activities related to the Medicare Secondary Payer Program.

Let me begin with a brief explanation of Blue Cross and Blue Shield of Maryland's role as a Medicare contractor.

Blue Cross and Blue Shield of Maryland has been the Part A Fiscal Intermediary for institutional providers and the Part B Carrier for physicians and suppliers in Maryland since 1966. In 1988, we became the Fiscal Intermediary for Washington, D.C. providers.

In fiscal year 1990, Blue Cross and Blue Shield of Maryland expects to process 1.5 million Part A claims and 5 million Part B claims and make nearly $2 billion dollars in payments for health care rendered to our 700,000 beneficiaries. We will spend just over $20 million dollars to administer the program, an amount equal to one percent of the total benefits paid.

In 1989, the Health Care Financing Administration (HCFA) ranked Blue Cross and Blue Shield of Maryland's Medicare operation the number two Part A contractor and the number one Part B contractor in the United States through the Contractor Performance Evaluation Program. This program evaluates contractors performance against standards set and judged by HCFA.

The Medicare Secondary Payer (MSP) Program is one of three safeguard programs established to ensure that Medicare Trust Fund dollars are appropriately spent. These safeguard programs produce over $3 billion in savings each year, more than Medicare's entire administrative budget in fiscal year 1990. The Medical Review and Provider Audit programs contribute to these savings, but my statement will specifically address MSP.

MEDICARE SECONDARY PAYER PROGRAM

The MSP Program was designed to ensure that Medicare payments are not made for services provided to beneficiaries who have other coverage that is primary to Medicare. According to MSP regulations, Medicare is the secondary payer for:

- claims involving Medicare beneficiaries age 65 or older who are entitled to benefits under employer group health plans (EGHP) based on their own employment or that of their spouse;

- claims during a period of up to 12 months involving beneficiaries entitled to Medicare solely on the basis of end stage renal disease and entitled to benefits under an EGHP;

- claims involving automobile medical, no-fault or any liability insurance;

- claims involving workman's compensation, black lung or Veteran's Administration benefits; and

- claims involving Medicare beneficiaries under age 65 who are disabled by Social Security definition and are entitled to benefits under a large group health plan (employers with 100 or more employees) based upon their employment or that of a family member.

Blue Cross and Blue Shield of Maryland's MSP Program has achieved a high level of success in its five years of operation. Our savings to the Government for fiscal year 1989 totaled more than $33.7 million. In that year, we spent $819,151 on MSP activities to achieve those savings.

For 1990, the savings estimates look even better. As of May 31, 1990, we spent $479,467 to achieve a savings of $32,441,330. Year to date then, for every $1 we have spent on MSP, we have saved $68.

The achievement of these savings is accomplished by two basic activities:

1. Obtaining primary payer information prior to payment of of a claim.

2. Using information gathered in the first process to identify prior erroneous payments and recover those dollars (case work).

MSP PROCESS FOR HOSPITALS

The success of the Part A MSP Program is largely dependent on the institutional provider giving Medicare the appropriate payer information at the time a claim is submitted.

HCFA mandates that hospital admitting clerks (inpatient) or registration clerks (outpatient) ask the patient a specific sequence of questions designed to determine whether Medicare is, in fact, the primary payer. A sample of these questions are:

- Was the illness/injury due to a work related accident/condition and covered by a workman's compensation plan or the Federal Black Lung Program?

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- Are you currently employed? Is your spouse employed? Are you covered by an employer group health plan?

In general, our findings are that inpatient admitting clerks tend to ask a majority of these questions on a fairly consistent basis. Many hospitals in Maryland and the District of Columbia use automated inpatient admission systems that include MSP questions that must be answered before the admission can be completed. These automated admission systems help to assure that we get at least some of the information we need to determine the primary payer.

On the other hand, we have found frequent problems with hospital outpatient registration procedures. Hospitals generally offer a wide range of outpatient services throughout many areas of the facility. Consequently, registration procedures are often dictated by the individual outpatient departments rather than by a consistent, hospital-wide procedure.

This leads to a fundamental problem. If the registration clerk in an outpatient area does not ask all of the mandated questions, the billing department does not have sufficient information to determine just who the primary payer is. It is difficult for the billing department to obtain the missing

information since by the time it is preparing the claim, the patient has left the hospital.

The result is that the billing department submits the claim to whomever appears to be primary which, in most cases, is Medicare. A code must be inserted on the face of the claim that indicates that primary payer information had been sought by the hospital. If that code appears on the claim, we assume that all the MSP questions were asked. This, in fact, may not be the case.

MSP DATA GATHERING METHODS

Knowing that we might receive erroneous or no payment information from hospitals, we have in place several other methods that we use to gather information about the primary payer.

First, HCFA has mandated a regional data exchange among Medicare contractors. On a quarterly basis, contractors in a given region share valid information for beneficiaries who have other coverage primary to Medicare. In this manner, accurate data can be kept on a beneficiary who, for example, receives treatment in both Maryland and Pennsylvania. The beneficiary may have been asked the appropriate questions in Maryland, but not in Pennsylvania. Maryland would have the correct data.

Pennsylvania would not. The regional data exchange allows contractors in a given region to share up-to-date payer information.

We are often able to determine that someone else is the primary payer through a check of HCFA/Social Security Administration (SSA) beneficiary records. Whenever we process a claim, our system searches the information contained within the HCFA/SSA records. If this information is valid and complete, we deny the claim.

If the information is incomplete, we notify the hospital of the potential secondary payer situation and ask them to provide more definitive information. If they are unable to do so, we contact the beneficiary in writing.

We occasionally find out about another primary payer from the beneficiaries themselves. They may notify us when Medicare should not have been the primary payer, and give us correct primary insurance information.

Once we identify a particular claim for which Medicare is not the primary payer, we examine the claims history for that beneficiary, looking for prior claims that may have been paid erroneously. If such erroneous payments are found, a case is established and passed on to a case worker who attempts to recover the Medicare payments.

PAYMENT RECOVERY

The process for recovering erroneous payments from hospitals and other Part A providers is relatively simple. We notify them in writing of the true primary payer and give them 45 days to submit a claim to that payer. At the end of the 45 days, we retract our original payment from their weekly remittance.

Recovering a Part B payment is much more complicated. We first contact the primary payer, notifying them of our erroneous payment and asking if they have also paid the claim(s) in question. If they have paid the claim(s), we attempt to recover our payment from the payee (provider or beneficiary). If the primary payer has not made a payment, we supply them with a copy of the claim(s) and request they forward a check to Medicare.

Current HCFA policy mandates that we send a series of three demand letters. If we receive no response from the insurer or payee, we forward the case to HCFA who will attempt a recovery on our behalf.

EDUCATION AND SURVEILLANCE

The Part A MSP Unit is mandated by HCFA to educate billing and admission/registration personnel on the specifics of MSP regulations and to monitor the hospital's compliance via an audit program. We are currently required to audit 10 hospitals per year.

The choice of which hospitals are audited is made by examining their past billing trends, the nature of their calls to the MSP Unit, and some provider-specific reports generated by our claims processing system.

Hospitals are notified, in writing, 30 days in advance of the audit; and asked to make available inpatient and outpatient financial records for a specific month. The MSP Senior Investigator conducting the audit examines these records to determine if the mandated MSP questions were asked. The Senior Investigator also observes the registration process. Once complete, a written report outlining the results of the audit is forwarded to the HCFA Regional Office.

CASE STUDY: JOHNS HOPKINS HOSPITAL

We have been asked by the Subcommittee to address our findings

from hospital audits in general, and, in particular, the Johns Hopkins Hospital audits.

The findings of audits we have conducted on Hopkins in both 1988 and 1990 are typical of the findings from other hospital audits.

In 1988, our MSP unit conducted an initial and follow-up audit of the Johns Hopkins Hospital. In our initial audit, we found that in 96% of the inpatient admissions examined, all or most of the MSP questions were asked.

On the outpatient side, we found no evidence that the MSP questions had been asked. At the time, Hopkins had 260 outpatient sites throughout Maryland and relied on a manual registration process.

Our recommendations to Johns Hopkins after the first audit were to train outpatient personnel in MSP requirements and to require that all MSP questions be asked at the time of every admission and registration.

During the follow-up audit, we found that all the MSP questions were still not being asked during the outpatient registration process. Hopkins had held training sessions for registration

personnel; but, according to hospital records, they were poorly attended. Immediately following the audit, Hopkins informed us that its strategic plan called for the installation of automated inpatient and outpatient registration systems by 1991.

On April 25, 1990 we conducted a second audit of Johns Hopkins Hospital. This audit showed virtually no change in inpatient or outpatient procedures. In most cases, the inpatient registrars continued to ask the mandated MSP questions. However, on the outpatient side, we found no evidence that MSP information had been gathered in any of the 75 records examined; so, it is possible that another primary payer existed in all 75 instances.

Some of the other problems noted were as follows:

- In some instances, the patient was allowed to determine which payer was primary rather than having the registrar decide by asking the mandated MSP questions.
- Information on the possible employment of a spouse was not always sought.

- If a registration record did not contain sufficient information to determine the appropriate primary payer, the billers "defaulted" to Medicare, using a code that indicated that the appropriate questions were asked and that Medicare was definitely the primary payer.

With these problems in mind, we made the following recommendations:

- The admission office should obtain MSP information for both the patient and the spouse;
- MSP questions should be asked of both inpatients and outpatients;
- The hospital should not allow the patient to determine the primary payer;
- Outpatient registrars should be trained on MSP regulations;
- Outpatient registration should be centralized;
- The Medicare primary code should not be used unless sufficient information was gathered to prove this to be true.

Once again, these findings and our recommendations are typical of the results of other hospital audits in Maryland and the District of Columbia.

BARRIERS TO SUCCESS

While still a young program, MSP has proven to be a valuable payment safeguard. It is Blue Cross and Blue Shield of Maryland's firm belief that MSP could provide even more value to the Medicare program were it not for certain barriers.

Since FY 1989, our MSP Unit has been inadequately funded for the recovery of erroneous payments. As hospitals' admission/registration procedures and other sources of primary payer information have improved, we have become more successful in identifying past erroneous payments. However, due to a lack of funding and the low priority assigned to casework by HCFA, we are not able to devote enough resources to the recovery of these erroneous payments.

Our budget request for FY 1989 included funding for an additional five MSP case workers. We were given two. Funding cutbacks in FY 1990 forced us to terminate those two case workers plus five more. Two years of inadequate staffing has created a backlog of over 7,000 cases. In real dollar terms, this lack of funding represents nearly $10.8 million in lost savings if you look at our current savings ratio.

RECOMMENDATIONS FOR IMPROVING MSP

In order to improve the performance of MSP and add even more to the Medicare Trust Fund, we offer the following recommendations:

SSA Information Gathering

As effective as our current information gathering methods are, we still frequently find ourselves in a "pay and chase" situation. If the Social Security Administration were to require every new Medicare beneficiary to complete and submit an MSP questionnaire prior to issuance of a Medicare card, Contractors would have valid primary payer information on file before the first claim was filed, minimizing the possibility of erroneous payments.

Funding

We believe HCFA should assign a high priority to the recovery of erroneous payments and provide increased, consistent funding for the MSP Program. At the current 68:1 savings ratio, this is one of the best bargains in the Medicare Program.

SUMMARY

In closing, the Blue Cross and Blue Shield of Maryland MSP Unit has proven to be extremely successful in safeguarding the Medicare Trust Fund. With some changes in the regulations and increased, consistent funding, it can be even more so. I appreciate the opportunity to discuss these issues with you today. We look for your continued interest and support as we work together to improve the administration of the Medicare Program.

2191x-1-16/7/10/90/JJJ

The
Johns Hopkins
Hospital

600 North Wolfe Street/Administration 3-309
Baltimore, MD 21205
(301) 955-5151

Constance L. Clark, C.P.A.M.
Director, Patient Accounting

Full Testimony Regarding MSP And
The Johns Hopkins Hospital

My name is Constance Clark. I am The Director of Patient Accounting at the Johns Hopkins Hospital and I am responsible for all of the hospital's billing components. On behalf of Hospital Administration, we are grateful to have this opportunity to share our views on Medicare Seconday Payor issues.

About The Johns Hopkins Hospital; We are a 1,000 bed inner city teaching facility which has annual gross Medicare revenues of approximately 92 million dollars with total net revenues of approximately 335 million dollars per year.

We have approximately 37,000 admissions and approximately 350,000 outpatient visits per year. We process on the average 8,800 inpatient bills to Medicare and 34,000 outpatient bills to Medicare per annum.

Currently we have over fifty different outpatient registration areas and four admitting offices in our large four-block complex for the convenience of our patients who may go directly to their treatment center for care and processing.

Our decentralized approach has many advantages relating to resource management, accountability and specialized patient care. Unfortunately one of our disadvantages with multiple points of registration is the ability to cost effectively monitor patient information gathering procedures and compliance.

In the past 18 months we have taken great strides to improve this situation. We have reorganized our Informational Systems Department with a mission to interface all patient care systems. In addition, we have purchased a state-of-the-art billing syste which we are now currently implementing.

JOHNS HOPKINS HEALTH SYSTEM

II. The Audit; Recently we were audited by our intermediary, Blue Cross of Maryland for our compliance with the Medicare Secondary Payor procedures. We received a report on that audit with eight recommendations. Listed here are the recommendations as well as our response to each item.

1. The admission department must obtain and document all information regarding employment status and insurance coverage for the patient and spouse.

   Our standard admission form and procedures include this information. The condition of the patient at the time of the interview may impact just how much information we can acquire. We do have financial counselors trained to go to the patient's room for additional information. We do try to be in 100% compliance.

2. All questions regarding MSP must be asked of all Medicare patients for both inpatient and outpatient admissions.

   Many of our patients do not understand why they must answer these questions over and over again. Many feel harassed, upset and often confused. Sometimes when they do tell us the correct information, the claim is rejected by Medicare because of faulty or obsolete information in their data base.

   We will be scheduling another training session for our registrars as well as implementing quality compliance procedures to document our progress.

3. When completing the admission form, negative responses should be indicated.

   We will stress this in our training sessions and monitor the responses during random audits.

4. The hospital should not allow the patient to decide which insurance should be the primary payer.

   We agree, but for those Medicare patients who have been through this many times, they are insulted that we don't think they know what coverage they have.

5. Centralize and, if possible, computerize the outpatient admission process.

   As previously mentioned, we have purchased a new

billing system. The inpatient portion is to be complete in December and the outpatient piece in September 1991. In the meantime, we are adding a new screen to our existing outpatient system as to document that our registrars are asking the right questions.

6. Train outpatient (clinics & ER) registration personnel and billing personnel on MSP regulations.

We have done this in the past and right now we are contracting with professional trainers to help us rectify the situation and insure compliance.

7. Update MSP information on recurring admissions ensuring that the employment and insurance information has not changed.

Our procedures are to ask these questions at every visit. We are implementing a quality audit program to be more proactive even when the form is completed.

8. Discontinue submitting bills with a condition code 09 to receive primary payments unless this information has been verified.

We have discontinued the use of this field on our billing tape. Currently we cannot assign condition codes on our outpatient tape program. This is one reason why we purchased a new billing system. We are currently studying this issue for an interim solution.

III. MSP Compliance History at The Johns Hopkins Hospital

Since the onset of the MSP requirements, The Johns Hopkins Hospital has spent well over $50,000 in compliance and tracking programs. This money is in addition to the cost of our new system which we are installing.

These are the steps we implemented prior to this audit;

1. We did have training sessions for all registration staff and admitting offices. We implemented the manual paper development form as well.

2. Approximately 30% of our registration areas do have an on line registration system (CAS). In 1988 we did implement the MSP screen for use on all Medicare patients.

3. We built an edit into out Billing System that matches all incoming registrations and compares the registration history of the patient. If the patient was registered as MSP, the new registration will reject and we manually develop the information in the billing office.

4. We did write an automatic program to report back to the intermediary our OPD MSP payor log information as required.

IV. Our Recommendations Concerning Medicare Secondary Payor Program

1. Educate the Medicare Patient;

Medicare patients do not understand why hospitals are making things difficult for them by asking all these questions at every visit. Even in the 1990 Medicare informational booklet, the first page where MSP appears is on Page 23. I feel that HCFA needs to advertise on TV and publish this issue more demonstratively in their publications.

2. Mandate current Data Base information within Social Security and/or the Intermediary.

We feel that the Hospital is not necessarily the best and only place to gather this information especially in light of the circumstances and conditions of our patients. Why not require this information through the Social Security Administration and Intermediary?

3. Perform a national study to ascertain a more accurate estimate of expected savings of the MSP program.

In our inpatient audit, there were only 14 patients out of 642 who were working aged. With more and more employees requiring more employee contributions for health coverage, we feel these ratios will decline.

4. Examine the reasonableness of requiring these MSP questions on every visit.

We suggest defining time periods that one registration data set be appropriate for outpatients. Hospitals are trying to implement systems for patient comfort and convenience. Patients should spend more time with their doctors than in registration lines.

5. Revise the MSP Questionnaire to avoid confusion for both Patients and Registrars. (See attached)

6. Recommendations for Hospitals;

The job description for Registrars may need to be re-evaluated in light of managed care and other regulatory requirements. Many hospitals typically rank registrars as entry level status or, in some cases, registrars are busy nurses who are doing both patient care and registration. We, at The Johns Hopkins Hospital, have begun this evaluation.

V. Conclusion:

With new technology and the impetus for hospitals and providers of health care to find alternatives to costly inpatient hospital stays, more and more patients are being treated as outpatients. These patients are older and sicker than they were ten years ago and the challenge to handle the patient registration process as comfortably and efficiently as possible is with hospitals and other providers of health care.

Whereas we realize the necessity of properly identifying payment coverages, we feel that there can and must be a balance between burdensome regulatory requirements and procedures which are less intrusive to our patients.

Last year alone, Maryland Medicaid and HCFA issued more than 200 billing/reimbursement procedural changes that affected hospitals. The Johns Hopkins Hospital spends over two million dollars monitoring and maintaining compliance and record keeping. We are confident that our additional action steps regarding MSP will be satisfactory and we are again, grateful for this time to share both our point of view as well as feed back from our patients.

DRAFT:

THE JOHNS HOPKINS HOSPITAL
MEDICARE SECONDARY PAYOR
CLAIM DEVELOPMENT QUESTIONAIRE

History # _____ Date Of Service _____

Patient's Name _____

Patient's Signature _____

As a direct result of Medicare (MSP) regulations, we are required to gather the following information on all Medicare patients to determine if Medicare is the Primary Insurance.

1. Is illness/injury due to an automobile accident, liability accident or workmen's compensation? ___ yes ___ no
2. Is illness covered by the Black Lung Program or Veterans Administration Program? ___ yes ___ no
3. If under age 65, are you a renal dialysis patient in your first 12 months of Medicare entitlement? ___ yes ___ no
4. If under age 65, is your Medicare coverage due to disability? ___ yes ___ no
5. Are you employed? ___ yes ___ no
6. Are you insured by employer? ___ yes ___ no
7. Are you retired? ___ yes ___ no
8. Date retired _____ ___ yes ___ no
9. Is spouse or other family member employed? ___ yes ___ no
10. Does spouse or other family member have insurance which covers you? ___ yes ___ no

INSURANCE INFORMATION

1. Name Of Insurance: _____
2. Address Of Insurance Co.: _____
3. Policy Or Membership Number: _____
4. Relationship Of Pt. To Policyholder _____
5. Policyholder's Name: _____
6. Name Of Employer: _____
7. Address Of Employer: _____
8. Date Of Accident If App. _____

PROVIDENT INTERNAL MEMORANDUM

H-190

TO: Mr. Bruce Brown
Group Department

February 8, 1983

FROM: Mr. Steve Carter

SUBJECT: MEDICARE SECONDARY
MERCER OPINION

The cost estimates of $1,500 to $1,800 per person estimated by Mercer are in line with our assumptions.

Currently, we are making a surcharge of $75 per month ($900 annually) for each employee or dependent who is age 65 to 69. In addition, a regular premium is being charged for them to the employer which typically ranges from $35 to $70. This means that we are typically charging our customers around $1,320 to $1,740 per person. Of course, these ranges vary considerably by cost area, type of integration approach that was formerly used, etc.

cc: Mr. T. L. Dunn

Attachment
931wc

GROUP CLAIM Bulletin

January 14, 1983

Medicare

We have been notified that some Medicare administrators will continue to pay claims incurred in 1983 on active employees ages 65 to 69 as primary for the first few months of 1983. Apparently they are not yet set up to handle secondary payment. Other Medicare administrators have announced that they will pay these claims as secondary.

In view of this inconsistency we must determine what the Medicare administrator is doing before making payment on this type of claim. If the administrator is continuing to pay as primary we should pay as secondary and be prepared to reimburse Medicare in the future if called upon to do so. A log of these claims should be kept for ready reference. If the administrator is paying this type of claim as secondary we should go ahead and pay as primary as previously instructed.

Revoked
(see G.B. 83-10)

GROUP CLAIM Bulletin

- NOTICE AND CONSENT TO TRANSFER ASSETS
- FLORIDA - CIVIL REMEDIES PROVISION
- MEDICARE CHANGES - JANUARY 1, 1983
- MID-YEAR PLAN CHANGES AND TAKEOVERS
- FAMILY COUNSELING

Notice and Consent to Transfer Assets

The various state requirements for notice and consent to transfer life insurance funds are outlined on pp.'s 161.1 thru 161.3 of the Group Claim Manual.

Please revise these pages to show that Colorado and Oregon now have statutes requiring payment of interest.

Also change the information for New York to show that notice is now required for payments to a beneficiary or to the estate if the amount is over $30,000 (previously $10,000).

Florida - Civil Remedies Provision

The Florida Insurance Code provides that a complaintant must give written notice of the violation to the insurance company in order to bring a court action seeking civil remedies. This notice must specify the facts which constitute the violation; the law upon which the complaintant is relying and must also state that the notice is being given to protect the complaintant's right to pursue the civil remedies authorized by the Florida Insurance Code.

Once this notice is given, the insurance company has 60 days in which to resolve the alleged violation without having to defend a court action. It is imperative that any claims on which such notice is given be immediately referred to the Home Office for review. Failure to do so would expose us to penalties and/or punitive damages, which are usually petitioned for in lawsuits involving insurance contract disputes.

Medicare Changes - January 1, 1983

Several Bulletins, both Group and Group Claim, have been released concerning the Tax Equity and Fiscal Responsibility Act of 1982 and the responsibility of Medicare and group medical programs for employees between ages 65 through 69. The Health Care Financing Administration has now released final regulations to the Medicare intermediaries.

The purpose of this bulletin is to revoke the claim processing instructions given in Group Claim Bulletin 83-1.

Effective immediately, claims from individuals covered by TEFRA (see Group Claim Bulletin 83-8) with no information as to the action taken by Medicare, should be paid as primary since that is our legal responsibility. No attempt should be made to obtain additional information.

Claims on which information is submitted that Medicare has paid as primary should be paid as secondary. The balance of our legal liability should not be paid until Medicare requests that they be reimbursed. Under no circumstances should our liability in excess of our secondary payment be paid to the provider(s) or the Medicare beneficiary.

Mid-Year Plan Changes and Takeovers

Previously, there have been no standards for handling the history on an account that changes coverage in the middle of a benefit period or on a new account acquired in the middle of a benefit period. History includes such things as deductible accumulations, payments toward maximums, out-of-pocket accumulations, etc.

The following procedures have now been established as the standard for these situations and the computer has been programmed to handle them in this manner for the balance of the benefit period in which the change occurs. Any deviation from this standard would require manual intervention by adjusters which is a time consuming task.

Plan Changes on Existing Provident Groups

The individual's claim history wil be carried forward to the new plan. This means if the individual has fully satisfied a $100 deductible under the old plan and the new plan deductible is $200, then that individual would have to satisfy an additional $100 of deductible.

If the new plan imposes inside limits on types of expenses which were previously unlimited, the plan change will be handled as though it were retroactive to the beginning of the benefit period. For example, if an individual has received more than $1,000 of prescription benefits since the beginning of the benefit period and the new plan imposes a $1,000 limit, then no additional payments would be made for prescriptions.

Takeover Groups From Other Carriers

If history is provided on individual claimants by the previous carrier, the same procedures will apply as for Provident's groups undergoing a plan change.

If individual history is not provided, credit can be given for deductible and out-of-pocket accumulations when evidence of such credit is furnished. This evidence may be a copy of the prior carrier's worksheet, an EOB or a statement from the group customer. Such evidence will not usually include prior payments toward the plan maximums so any inside limits imposed by the new plan will not reflect any prior payments and benefits can be paid up to the maximum provided by the new plan.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

J. Holloway - For your information. I don't believe we have anything pertaining with this yet - J.J.J. 1-17

Memorandum for File

January 12, 1983

Re: Medicare - TEFRA

Blue Cross of Tennessee has notified American Enka in Lowlands, Tennessee that Medicare administered by Blue Cross of Tennessee will continue to pay claims on active employees ages 65 to 69 and their dependents on a primary liability basis for the first few months of 1983 as there will be a delay in implementation of the TEFRA amendments. Blue Cross has further notified American Enka that Blue Cross will be paying in their role as group carrier secondary benefits on these claims. Apparently the communication does not say anything about how long this will go on or whether they will eventually be a settling up.

Sam Holloway is getting a copy of this communication sent to us right away.

It seems to me we had better get something out to our Field Claim Offices pronto indicating to them that our action on Medicare claims for the first few months of this year should be based on what the Medicare intermediary does. In other words, we should not automatically assume the Medicare intermediary is going to pay as secondary but should find out whether Medicare is going to pay as primary or secondary in a given case. If Medicare pays primary liability, we do not want to turn around and also pay primary liability.

My guess would be that the government is going to come back to us for adjustments on claims on which they pay primary but on which they later determined that Medicare should have been secondary. So, we will need to keep a log of any such claims and be prepared to make adjustments later on.

T. J. Johnson, Jr.

sn

cc: Mr. P. J. Haverty
Mr. Jack Kerr

Note to Mr. Jack Kerr

Jack, could you get a Claim Bulletin out on this on a rush basis, please.

T. J. J.

bc: Mr. J. J. Gribben
Mr. A. R. Hall
Mr. R. E. Adams

Senate Permanent Subcommittee on Investigations
EXHIBIT # F

Senate Permanent Subcommittee
on Investigations

EXHIBIT # G

PROVIDENT INTERNAL MEMORANDUM

ACCIDENT COMPANY

•••••••••••••••• FILE COPY ••••••••••••••••

TO: Mr. P. J. Anzalone
Group Department

July 11, 1983

FROM: T. J. Johnson, Jr.
Group Department

SUBJECT: TEFRA - Medicare

In response to your memorandum of July 7, 1983, with which you sent a copy of Phyllis O'Connor's memorandum of June 29, 1983, we have given our Field people the very best information we have on TEFRA and we've also told our people what our position is as respects the surcharge.

Group Bulletin No. 2 of 1983 dated January 27, instructed our people to adjudicate claims on persons age 65 through 69 on the basis of whatever action is taken by the particular Medicare fiscal intermediary. It also explained our positioin as to the surcharge.

A Bulletin published in April 1983 explained the Health Care Financing Administration's regulations, including the fact that HCFA is charging fiscal intermediaries with the task of recouping from private health plans and private insurers, where those plans originally paid as secondary subsequent to January 1, 1983.

In answer to the question Phyllis says she is still getting about why Provident is making a surcharge if Medicare is still paying as primary, the simple answer is that we are legally obligated for primary benefits back to January 1, 1983, and the federal people can come after us for additional payments in cases where we paid secondary; and indications are that Medicare intermediaries in other areas are now beginning to pay as secondary carrier.

he slowness of the federal government in getting regulations issued and getting instructions to Medicare administrators has created a confusing situation. However, it seems to me we've got to live with this as best we can - and where we are asked about the surcharge, make it clear that we are legally obligated for primary benefits as of January 1, 1983; and may have to go back and pay additional benefits on claims on which we have paid secondary benefits since that time.

TJJ:sln
0600U

cc: Mr. Bruce Brown
cc: Mr. J. H. Althaus
cc: Mr. T. L. Dunn
cc: Mr. F. W. Watson

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

COPIES to Ross, Stark, Dick, Janice
Ron, Afa, Carolyn, Renai

To: All Adjusters
From: Phyllis O'Connor
Date: June 28, 1983

Senate Permanent Subcommittee on Investigations
EXHIBIT # H

Subject: Medicare
"Signature On File"
Extended Benefits On Policy Termination

MEDICARE

It's now fairly clear that, throughout the country, Medicare Administrators are still paying as primary. If we pay as primary, in many cases Medicare will also, and the insured is getting paid twice. Therefore, until further notice, let's go back to being secondary to Medicare on all charges. Request Medicare EOB's when necessary, just as we used to. Please do not make any attempt to go back and adjust possible overpayments while we were paying as primary. Any complaints from policyholders regarding the "surcharge" on their premium billing should be referred to the Service Representative.

"SIGNATURE ON FILE"

More and more providers are using computerized billing systems,which produce statements or standard claim forms. These forms will often have the statement "Signature on File" in the assignment section. Unless we have reason to believe that this statement is not correct, we should accept this as an assignment on bills under $500.00. On larger bills, we should first call the providers office and confirm that they have a valid,current assignment and make a note to this effect in the file.

EXTENDED BENEFITS ON POLICY TERMINATION

Under most of our policies, the Extended Benefits Provision ceases to apply "as of the date you or the Dependent becomes insured under any other similar group plan------" Most carriers will not insure a disabled employee until he or she returns to work, so we will almost alwa be obligated to pay Extended Benefits on a disabled employee when our policy terminates. However,most carriers will pick up claims on disabled dependents,which means that we should never automatically allow Extended Benefits for disabled dependents on policy termination. The claim should be filed with the new carrier first; if they deny the claim, they should be asked to supply us with a copy of their policy provision which specifically gives them the right to deny claims on disabled dependents. (usually, no such provision exists, and they will end up paying the claim.) If you run into any problems with this, please refer them to me or the Service Representative for the account.

Form G.2029-B (REV 1-83)

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

To: All Adjusters
From: Phyllis O'Connor
Date: January 18, 1983

Subject: Medicare:

We've heard that the Kiplinger Newsletter had a recent article stating that the January 1, 1983 changes making Medicare secondary to other insurance were being deferred.

I discussed this with Home Office and was told that we're making no changes in the way we've planned to handle Medicare, because there hasn't been a final official set of guidelines issued yet.

For the moment, let's go ahead and pay as primary as originally stated. However, if we receive a bill (such as a hospital bill) which has already been paid by Medicare, pay that bill as secondary carrier according to the old Medicare arrangement.

This could be confusing, and we can't guarantee that further changes won't be coming up. From now on, let's keep a log of all Medicare claims paid for expenses after January 1, 1983. This way, if we are required to go back and make adjustments, we can identify the file

Please refer all questions to your Unit Leader.

Phyllis O'Connor

FORM G.2029-B (REV. 1-63)
Printed in U.S.A.

FILE: TEFRA ~~GLEN, JS, DK~~ JUL 05 REC'D

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

To: P. J. Anzalone
From: Phyllis O'Connor
Date: June 29, 1983

Subject: Medicare (TEFRA)

Dear Phil:

It appears that, throughout the country, Medicare administrators are still paying as primary carrier. This is certainly the case here and we've even heard of cases where both Medicare and Provident have paid as primary on the same bill.

For this reason, I've instructed our adjusters to go back to requesting copies of Medicare payments on all bills submitted and to pay as secondary carrier on all claims. (In practice, we've been paying secondary benefits on hospital claims all along, since the hospitals have been filing with Medicare first. On doctor and other claims, we pay as primary if they file with us first, but this no longer seems to make any sense.)

I've already had the question from a couple of policyholders, "If Medicare is still paying as primary carrier, why are we paying Provident the surcharge?" It seems to me that we'll be getting more questions like this, and I'm wondering if any consideration has been given to suspending the surcharge until such time as the Medicare administrators start implementing the TEFRA provisions. I've instructed our adjusters to refer questions about surcharges to the Service Representatives; they can handle the questions better, but there is no easy answer.

Any information on this subject would be appreciated.

Sincerely,

Phyllis O'Connor

POC/mbh

cc: Joe Gribben (Home Office Group)
Ron Schenck (Home Office Claims)
Ron Thompson, Wyn Lewis, Carolyn Farrell (Santa Ana Group)
Ross Williams, Steve Parham, Dick Russell, Janine Todd (Los Angeles Group Office)
Debbie Cutter (Santa Ana Group)

Form G.2020-G (REV. 1-63)
Printed in U. S. A.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

To: P. J. Anzalone
From: Phyllis O'Connor
Date: June 29, 1983

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Any information on this subject would be appreciated.

Sincerely,

Phyllis O'Connor

POC/mbh

0000702

cc: Joe Gribben (Home Office Group)
Ron Schenck (Home Office Claims)
Ron Thompson, Wyn Lewis, Carolyn Farrell (Santa Ana Group)
Ross Williams, Steve Parham, Dick Russell, Janine Todd (Los Angeles Group Office)
Debbie Cutter (Santa Ana Group)

FORM G.2028-B (REV. 1-83)
PRINTED IN U.S.A.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

Mr. T. J. Johnson

July 7, 1983

Group Department

TEFRA

Tom, attached is a memo I received from Phyllis O'Connor concerning TEFRA and our payment as primary carrier for employees ages 65-69. I'm not sure who should have the responsibility for replying to Phyllis but certainly a position from the home office should be established and a response given to our field offices.

If it is true that some Medicare administrators are still paying as primary carrier, does that imply that we are off the hook; or, can it be assumed that there will be a reversal of these payments and a request eventually made to the Provident for payments made since January 1? This whole area is very confusing and, obviously, is creating a good deal of difficulty in the claim payment area throughout our field organization.

P. J. Anzalone

Phil

ar
1723R
Attachment
cc: Mr. Bruce Brown
Mr. Jim Althaus
Mr. Foy Watson

0000701

Form G-2029
Printed in U. S. A.

PROVIDENT INTERNAL MEMORANDUM

TO: Mr. P. J. Anzalone
Group Department

July 11, 1983

FROM: T. J. Johnson, Jr.
Group Department

SUBJECT: TEFRA - Medicare

In response to your memorandum of July 7, 1983, with which you sent a copy of Phyllis O'Connor's memorandum of June 29, 1983, we have given our Field people the very best information we have on TEFRA and we've also told our people what our position is as respects the surcharge.

Group Bulletin No. 2 of 1983 dated January 27, instructed our people to adjudicate claims on persons age 65 through 69 on the basis of whatever action is taken by the particular Medicare fiscal intermediary. It also explained our positioin as to the surcharge.

A Bulletin published in April 1983 explained the Health Care Financing Administration's regulations, including the fact that HCFA is charging fiscal intermediaries with the task of recouping from private health plans and private insurers, where those plans originally paid as secondary subsequent to January 1, 1983.

In answer to the question Phyllis says she is still getting about why Provident is making a surcharge if Medicare is still paying as primary, the simple answer is that we are legally obligated for primary benefits back to January 1, 1983, and the federal people can come after us for additional payments in cases where we paid secondary; and indications are that Medicare intermediaries in other areas are now beginning to pay as secondary carrier.

The slowness of the federal government in getting regulations issued and getting instructions to Medicare administrators has created a confusing situation. However, it seems to me we've got to live with this as best we can - and where we are asked about the surcharge, make it clear that we are legally obligated for primary benefits as of January 1, 1983; and may have to go back and pay additional benefits on claims on which we have paid secondary benefits since that time.

TJJ:sln
0600U

cc: Mr. Bruce Brown
cc: Mr. J. H. Althaus
cc: Mr. T. L. Dunn
cc: Mr. F. W. Watson

PROVIDENT INTERNAL MEMORANDUM

ACCIDENT COMPANY

********** FILE COPY **********

TO: Mr. P. J. Anzalone
Group Department

July 11, 1983

FROM: T. J. Johnson, Jr.
Group Department

SUBJECT: TEFRA - Medicare

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TJJ:sln
0600U

cc: Mr. Bruce Brown
cc: Mr. J. H. Althaus
cc: Mr. T. L. Dunn
cc: Mr. F. W. Watson

0000710

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

COPIES — Ron, Wyn, Carolyn, La Verne
Ross, Steve, Dick, Janine
Debbie, Michelle, Marti

PERSONAL

Ms. Phyllis M. O'Connor

July 21, 1983

Santa Ana Group Office

P. J. Anzalone

TEFRA - Medicare

Dear Phyllis:

This is the response I received regarding your memo of June 29. I think Tom makes a good point. We are legally obligated and have no choice in the matter.

Sincerely,

PJA:ar
1860R

Form G-2029

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

All Adjusters
February 1, 1984

Phyllis O'Connor

Re: Medicare - "TEFRA"
(Tax Equity And Fiscal Responsibility Act of 1982)

Much has been written regarding the changes effective 1-1-83. The questions and answers below are taken from the most recent group claim bulletins and claims should be handled as outlined until further notice.

Q. What do the Regulations which went into effect 1-1-83 provide as to whether Medicare is primary or secondary?

A. (From Group Claim Bulletin 83-8):
(1) if active employee is age 65 through 69 and dependent is age 65 through 69 - Medicare is secondary for both;
(2) if active employee is age 70 or over and dependent is age 70 or over - Medicare is primary for both;
(3) if active employee is age 65 through 69 and dependent is over age 70 - Medicare is secondary for the employee and primary for the dependent.
(4) if an active employee is under age 65, or is age 70 or older, Medicare is primary for any dependent age 65 or older.

Q. In some cases, Medicare is still paying as primary. How is this to be handled?

A. (From Group Claim Bulletin 83-10):
Effective immediately, claims from individuals covered by TEFRA (see Group Claim Bulletin 83-8) with no information as to the action taken by Medicare, should be paid as primary since that is our legal responsibility. No attempt should be made to obtain additional information.

Claims on which information is submitted that Medicare has paid as primary should be paid as secondary. The balance of our legal liability should not be paid until Medicare requests that they be reimbursed. Under no circumstances should our liability in excess of our secondary payment be apid to the provider(s) or the Medicare beneficiary.

Q. What if a patient has Medicare because of permanent and total disability or Kidney Dialysis?

A. (Summarized from Bulletins 81-11 and 82-11, Original and Revised):
Persons on Medicare because they've received Social Security disability benefits for 2 years would not be considered as "active employees". Regardless of their age, Medicare is primary. Medicare is secondary to private insurance during the first 12 months of treatment for end-stage Renal Disease; after that, the rules specified under the first question would apply.

If there are other Medicare questions that need to be addressed in a memo, please submit them in writing to your Unit Leader.

Form G.2028

PROVIDENT INTERNAL MEMORANDUM

TO: Mr. E. M. Nelson
Tampa Group Office

February 7, 1983

FROM: Mr. S. T. Carter

SUBJECT: MEDICARE

Dear Pete:

Thanks for your letter. I don't know how Florida Blue-Cross/Blue Shield is administering Medicare but regardless of that, it appears that unless the government agrees to certain changes we are legally primary as of January 1, 1983. I believe the recent Group Bulletin Volume 1983-#2 put out by Tom Johnson will cover this in more detail.

938wc

Form CG-2029

PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

Mr. Charles Griffith

Group Department

September 8, 1983

Donald F. Reardon

cc: Jim Althaus
Phil Anzalone
Henry Dicks
John McCleve
Pat Haverty
Joe Gribben
Laten Creech

T E F R A

Dear Charlie:

I don't know if I should write you on this or someone else. If it is not your bailiwick, may I ask that you please pass it on to "whoever."

The Medicare provider in New York (it happens to be Blue Cross) has been paying claims on persons 65 through 69 as a primary carrier. At the same time we have been billing our New York accounts with a billing surcharge on the assumption that we have the primary responsibility. Our Bloomfield Claim Office has been paying as a secondary carrier, and as far as I know, they are still doing so.

Many of our customers have complained thay are/were being surcharged for a liability which we have not assumed yet. As a matter of fact, several brokers and customers have approached me for a refund of the surcharge.

Upon referring back to Group Bulletin 1983 No. 2, I see that "...if in the final analysis, it develops that Medicare has primary liability during any period subsequent to January 1, 1983, thus deferring our change to a primary liability situation, we will agree to a retroactive adjustment in which we would credit back the surcharges for the appropriate period".

It is my request that we refund to all our New York customers the surcharges that have been collected in the past months.

It is quite obvious to everyone that Medicare has no way of knowing who in their claim files is an active employee working for an employer of 15 or more employees. Consequently, they never will be able to track this down and pass it back to the insurance industry.

0000787

Also, because of the reasons given here, I would question our adding to the normal rate increase on any New York group an additional amount to cover the "phantom" liability of being primary for active employees 65 to 69. As I understand it--in New York--that liability does not exist for us yet.

May I ask that someone please take all this into consideration and let me know what our position is to be.

Thank you.

Sincerely,

Donald F. Reardon
Associate Regional Manager

DFR:rmt

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE

Mr. Don Reardon

September 13, 1983

Bloomfield Group Office

Charlie Griffith

TEFRA

Senate Permanent Subcommittee on Investigations

EXHIBIT # K

Dear Don:

Thank you for your letter of September 8. I am not sure this is in my bailiwick either, but I have looked into it and hopefully can give you the basis upon which we propose to operate.

We know what the law is, we know what we should be doing, but there is not a thing we can do to change the inadequacies or ineptness of the Medicare administrators. Accordingly, we intend to pay as primary carrier where we are, under the law, primary unless the claim submitted to us is accompanied by evidence that the Medicare administrator has already paid as primary. Obviously, there is a chance that the individual may receive an overpayment. However, we can't attend to everybody else's business, and all we can do is handle the claim in accordance with our understanding of the law and the information submitted with the claim.

The law is very clear in that we have liability as primary carrier beginning January 1, 1983. It may be years before we know how much of the offsets we have taken since January 1, will have to ultimately be paid to Medicare administrators and/or the Federal Government. As a result, we do not intend to refund surcharges that have been made since the first of the year, and we will continue to include in renewal requirements estimates of this additional liability. We have no alternative, Don, but to price this thing based on the liability we know we have under the law.

You state that "it is quite obvious to everyone that Medicare has no way of knowing who is in their claim files . . ." It may not be that obvious, Don. We know of one situation in Florida where a Medicare administrator has come after recoupment of over $10,000 from a group carrier in connection with a change in the Medicare law relating to kidney dialysis. The claim in question dates back over two years ago. Admittedly, this is a lot of money, and we might not be facing the same types of situations on the "nickel and dime" claims, but it does indicate that it could be a long time before the dust settles on who is liable for what during the first six to nine months of 1983.

To sum up, we are going to pay as primary unless there is specific evidence that the Medicare provider has already paid as primary, and we are not going to be refunding surcharges or additional charges made in connection with this liability.

Let me know if you have any questions or any additional comments on this.

Best regards.

Sincerely,

CRG:dr
2584R
cc: Mr. J. H. Althaus
Mr. P. J. Anzalone
Mr. P. J. Haverty
Mr. J. J. Gribben
Mr. L. L. Creech
Mr. J. McCleve
Mr. T. H. Dicks

Campbell SOUP Company

CAMDEN, NEW JERSEY 08101-2499

Senate Permanent Subcommittee on Investigations

EXHIBIT # 4

June 29, 1983

Mr. Ray Millard
PROVIDENT LIFE & ACCIDENT
INSURANCE COMPANY
Fountain Square
Chattanooga, TN 37402

RE: TEFRA - JANUARY 1, 1983

Dear Ray:

You have several memorandums from us on the above-referenced subject. We have sent you recent Updates from various consultants and we are now attaching TPF&C's Update dated June 1983.

Based upon our latest draft letter to you, we believe we are in compliance except:

1. Notice to employees. A notice must be prepared giving the employees an election right. Do you have a sample notice that we can use and send to our employees.

2. Active employees under 65 who are covered by Medicare and spouses under 65 of active employees under 65 where the employee and/or spouse is covered by Medicare. In this type of situation, is it your understanding that the employer's plan is primary and Medicare secondary. (See page 2 of TPF&C's letter, paragraph entitled "Who Is An Employee?")

I would like to clean up this situation as soon as possible. Since I previously instructed the plants and Provident to implement TEFRA as of January 1, 1983, meaning Campbell's primary and Medicare secondary, I believe that the number of dollars of reimbursement to Medicare should be minimal. We could possibly have reimbursements involving the under 65 employees and under 65 dependents who are covered by Medicare for Renal Dialysis.

Please have your Claim Department give you, and in turn me, a write-up on how you desire Medicare to be reimbursed in cases where we have provided benefits on a secondary basis.

Sincerely,

CAMPBELL SOUP COMPANY

R. E. Grossmann
Director - Employee Benefits

REG/jml

cc: Mr. G. Felton

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY

CHATTANOOGA, TENNESSEE

July 6, 1983

Ray Grossmann
Campbell Soup - General Office

TEFRA - January 1, 1983

Dear Ray:

Your June 29, 1983 letter on the above subject addressed the following areas:

(1) You asked for a sample notice to employees. I sent you a copy of our Group Bulletin No. 13, Volume 1983 on Friday, July 1, 1983, but it was after you had already mailed the above referenced letter. Another copy is attached for your convenience.

Attached to that bulletin is a sample letter to employees and an election form which were both prepared by Tom Johnson. Tom feels they are sufficient to satisfy the requirements of the regulations.

(2) You asked if it was our understanding that the employer's plan is primary and Medicare secondary for active employees under 65 who are covered by Medicare and spouses under 65 of active employees under 65 where the employee and/or spouse is covered by Medicare. You also referred us to page 2 of the TPF&C update which was attached to your letter.

Both the HCFA and EEOC regulations cover employees age 65 through 69. If an employee is under age 65, it is presumed that Medicare may remain primary. The EEOC mandates that spouses of those employees age 65 be treated like spouses of younger employees. Consequently, Medicare as primary is permissible. HCFA has no rules for spouses under 65 years old.

Therefore, we feel the law only applies to the age 65-69 age bracket. (Glenn Felton's June 20 , 1983 letter to me, of which I sent you a copy, deals with end-stage renal disease, which is covered under seperate regulations.)

(3) You asked for a write up on how we desire Medicare to be reimbursed in cases where you have provided benefits on a secondary basis.

TEFRA does not require, and we do not suggest that anything be initiated regarding unsolicitated reimbursement.

We feel this is up to Medicare based on the regulations, and they have the option of requesting or not requesting reimbursement.

By copy of this letter to Pat Haverty, I am asking that he make further comments to you regarding item (3) if he feels necessary.

Please let me know if you have any additional questions.

Sincerely

Ray Millard

RM:bgw:7517e

cc: T. J. Johnson
cc: P. J. Haverty
cc: Glenn Felton

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

AGENCY, BRANCH OFFICE AND HOME OFFICE CORRESPONDENCE.

Senate Permanent Subcommittee on Investigations
EXHIBIT # M

Mr. H. E. Bullington — April 15, 1983

Greensboro Group Office — J. A. Reynolds

[redacted]

Dear Horace:

Attached is a special agreement letter signed by Joe Gribben for a retro in connection with TEFRA/Medicare.

Please return the signed duplicate of this letter to me when it has been executed by the policyholder.

Best regards.

Sincerely,

JAR:jr

Attachment

cc: Mr. Mr. T. J. Johnson
Mr. P. J. Anzalone
Mr. J. J. Gribben
Mr. J. A. Jones
Mr. R. D. White
Mrs. Marian Kirkpatrick

0000589

Form G-2028
Printed in U. S. A.

PROVIDENT
LIFE & ACCIDENT
INSURANCE COMPANY
CHATTANOOGA, TN 37402

April 11, 1983

[redacted]

Provident Group Insurance Plan

Gentlemen:

This letter will confirm our understanding with your Company regarding premium payments for your Provident Group Insurance Plan. This arrangment is separate from and in addition to any other agreement between your Company and the Provident regarding the operation of your Provident Group Insurance Plan.

In accordance with your request, the Provident is agreeable to continuing to provide insurance effective January 1, 1983, at premium rates which contain no surcharge for increased medical expense benefits for active employees of your Company and their covered dependents age 65 through 69 who are eligible for Medicare but for whom your Provident Group Insurance Program is the primary insurance carrier for payment of medical expense benefits in accordance with the provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

Therefore in consideration of this, it is understood and agreed that, in the event the Provident is subsequently required to adjust medical expense benefit claim payments to the primary insurance carrier basis for any claim on which the Provident has made payment as secondary insurance carrier, your company will pay to the Provident as additional premium for insurance for any policy period ending after January 1, 1983, the amout by which:

(a) total medical expense benefit claim payments determined on the basis of the Provident's being the primary insurance carrier of your plan for such policy period for such active employees and their covered dependents age 65 through 69, as described above, exceed

(b) total medical expense benefit claim payments actually made by the Provident as secondary insurance carrier for sucy policy period for such employees and dependents.

In no event however will the amount of the additional premium exceed the aggregate amount of the surcharge for any such policy period that was not effected a[illegible] 1983.

Any such additional premium will be due and payable within thirty-one days after receipt of the Provident's statement indicating the amount of such premium

If the arrangement described in this letter is in accordance with your understanding, we would appreciate your indicating your acceptance in the space provided below and returning the duplicate of this letter for our file.

Yours very truly,

COPY

J. J. Gribben
Assistant Vice President,
Group Department

JJG:JAR:jij

Accepted:

[redacted]

Title:_____

Date:_____

5784e

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
AGENCY ASSOCIATE AND HOME OFFICE CORRESPONDENCE

Joe Gribben

May 21, 1985

Group Department - HO

John A. Dail

Re: [redacted]

Dear Joe:

Recently you provided me with a letter of agreement for the above policyholder dealing with the medical claim for the dependent husband of one of their employees. I am enclosing to your attention the signed agreement letter from the policyholder and would appreciate your making sure all records are so noted. Please note also that the group policy number is [redacted] not [redacted] This was changed on the letter.

Joe, your assistance is greatly appreciated. If you have any questions or need my assistance, please let me know.

Sincerely yours,

JAD:ilg

cc: Chip Starling - Atlanta Group Office

FILE COPY

PROVIDENT INTERNAL MEMORANDUM

Mr. J. A. Dail

May 3, 1985

Charlotte Group Office

[redacted]

Dear John:

Enclosed are two copies for signature and two extra copies of the agreement letter which we discussed on the telephone on Thursday in connection with Medicare's payment of the claim on the dependent husband of [redacted] on a primary basis.

This letter is what you had in mind, please have it acknowledged by the policyholder and a copy to us for our file.

Thanks very much, John.

Sincerely,

JJG:lg
3934h

cc: Mr. G. M. Cooper

PROVIDENT
LIFE & ACCIDENT
INSURANCE COMPANY

May 3, 1985

[redacted]

[redacted]

Gentlemen:

This letter will confirm the handling of the medical claim for the dependent husband of your employee, [redacted]

[redacted] Equity and Fiscal Responsibility Act of 1982 and the Deficit Reduction Act of [redacted], along with implementing regulations, provide that an employer's private health plan will provide primary health coverage for active employees age 65 through 69, and for age 65 through 69 dependents of active employees, with Medicare providing secondary coverage, unless the employee or dependent elects in writing to terminate coverage under the employer's private health plan, in which event Medicare would provide primary coverage.

On the medical claim for the dependent husband of your employee, [redacted] Medicare has continued to provide primary coverage even though [redacted] elected to have your plan provide the primary coverage. Because of this, and in order to avoid overpayment of the claim, Provident has provided secondary coverage on the claim.

The regulations under these laws provide further that in the event Medicare erroneously pays a claim on a primary basis rather than secondary, Medicare has the authority to require reimbursement of the overpayment by the employer's private health plan.

This letter will confirm the understanding that in the event Provident is required to reimburse Medicare for overpayment of the claim by Medicare during the policy year which began August 1, 1984, the amount of reimbursement to Medicare by Provident will be applied toward the $50,000.00 pooling level applicable to individual claims under your plan.

If the arrangement outlined in this letter is acceptable, we would appreciate your indicating your acceptance in the space provided below and returning a copy of this letter for our file.

Yours very truly.

J. J. Gribben
Assistant Vice President,
Group Department

JJG:lg
3932h

[redacted]

By: _____

Title: _____

Date: _____

PROVIDENT INTERNAL MEMORANDUM

TO: Dana Reynolds

March 5, 1985

Item 4 = (Var.)

FROM: Marilyn Shelley

SUBJECT: Medicare

A recent EBPR Research Report contained the federal regulations for Medicare as secondary payor on active employees or spouses who are 65-69 years of age.

The last page of the report outlines Medicare's requirements for conditional payments and recovery of payments. In view of paragraphs (a) and (b), do you agree we need to address a change in our procedure for processing claims on this age group of active employees and/or their spouses? Our present method of claims administration is outlined in the Group Claim Bulletin dated 83-1.

In my opinion, our previous claims instructions create:

1. Delays in plan benefit payment.
2. Frustration, time consumption and payment error potential for claim adjustors.
3. Time loss and aggravation in maintaining a manual log of these claims.
4. High costs involved when we eventually are required to refund Medicare. The time spent researching and reversing claims will be enormous.
5. A violation of federal law when we pay as secondary carrier.

I feel, as does Fount Love, we should notify (Concepts, perhaps?) our claim locations to issue plan benefits as primary carrier on claims involving active employees and/or their spouses who are 65-69 years of age without regard to Medicare's coordinating capabilities.

3063x

cc: Barbara Rose

File Copy

$445

Senate Permanent Subcommittee on Investigations

EXHIBIT # P

provident

EMP NAME

OPERATION LOCATION NUMBER: 03146 1 3315501

PROVIDENT CLAIM OFFICE
P.O.BOX 30276
TAMPA, FL. 33630

CLAIM TYPE
MEDICAL

REFERENCE NUMBER EMPLOYEE ID

DATE PROCESSED SERVICE DATE

PATIENT-NAME / RELATIONSHIP

PLAN NAME

OUR FILES INDICATE THAT THE PATIENT ABOVE IS ALSO COVERED BY MEDICARE.

SINCE OUR PLAN IS CONSIDERED TO BE THE SECONDARY CARRIER, ALL CLAIMS MUST BE FILED WITH MEDICARE FIRST FOR BENEFIT DETERMINATION AND PAYMENT. AT THAT TIME, PLEASE SEND US A COPY OF THE PAYMENT EXPLANATION FROM MEDICARE SO THAT WE CAN CALCULATE THE CORRECT AMOUNT OF BENEFIT.

THANK YOU FOR YOUR HELP.

SINCERELY
PROVIDENT
GROUP CLAIM SERVICE

TA4-SLB
L#016-000 060586 003799

provident

HP NAME: OPERATION LOCATION NUMBER:

PROVIDENT CLAIM OFFICE
P.O. BOX 171806
MEMPHIS, TN. 38117

CLAIM TYPE
MEDICAL

REFERENCE NUMBER EMPLOYEE ID

DATE PROCESSED SERVICE DATE
02/02/84 121783-122083

PATIENT NAME / RELATIONSHIP

PLAN NAME

WE HAVE RECEIVED A CLAIM FOR THE ABOVE PATIENT WHICH SHOWS THE FOLLOWING EXPENSES:

PROVIDER :
DATE(S) : 12/17/83 - 12/20/83
AMOUNT :

WE ARE UNABLE TO COMPLETE THE CORRECT PROCESSING OF THIS CLAIM UNTIL WE HAVE RECEIVED A COPY OF THE EXPLANATION OF BENEFITS PAID BY MEDICARE.

PLEASE ATTACH THE COPY TO THIS LETTER AND RETURN IT TO THE PROVIDENT ADDRESS SHOWN ABOVE SO THAT WE CAN GIVE YOUR CLAIM PROMPT HANDLING.

THANK YOU FOR YOUR HELP.

SINCERELY
PROVIDENT
GROUP CLAIM SERVICE

ME2-SFH
L0001-000 020284 003

TET:sem
#3002-12

IN THE CIRCUIT COURT OF THE 11TH JUDICIAL CIRCUIT IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO: 85-10113 CA 15

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY,

Plaintiff/Counter-Defendant,

vs.

T. ARMLON LEONARD, JR., et al.,

Defendants/Counter-Plaintiffs.

AFFIDAVIT OF ANNA MAE HILLENBRAND

STATE OF)
)ss:
COUNTY OF

BEFORE ME, the undersigned personally appeared ANNA MAE HILLENBRAND who, upon being duly sworn, deposes and says:

1. My name is Anna Mae Hillenbrand and I presently reside at 721 Chateau Drive, Evansville, Indiana 47715.

2. I am sixty-nine (69) years old and my date of birth is July 4, 1917.

3. On April 20, 1984, I retired from my employment with The Macke Company.

4. While employed at The Macke Company, I participated in Macke's group health insurance plan along with all of the other employees.

5. The group health insurance plan at Macke was provided by Provident Life & Accident Insurance Company, and all employees who participated in the plan paid premiums of $2.50 per week plus $100.00 deductible for comprehensive medical insurance coverage.

6. On January 28, 1983, I was hospitalized until February 10, 1983, for an illness, and I incurred hospitalization and other medical expenses in connection with that illness. Since I was over sixty-five (65), I submitted claims to Medicare and to Provident Life & Accident Insurance Company for all of these expenses which were for medical services rendered between January 28, 1983 and

February 11, 1983.

7. Medicare paid a portion of the medical expenses, and since I had heard nothing from Provident Life & Accident Insurance Company, I paid the balance which Medicare did not pick up. After that, I repeatedly contacted Provident to get reimbursed for that portion of the bills that I paid which Medicare did not pay.

8. Since Provident delayed paying me for so long, I became disenchanted and submitted a written complaint to the Department of Insurance, Consumer Services Division with the State of Indiana on May 31, 1983. I have attahced a copy of the letter submitted to the Department of Insurance on May 31, 1983 together with the exhibits that I provided to the Department of Insurance.

9. On June 6, 1983, I wrote to the Department of Insurance again since I had acquired information on a Federal law which affected my group health insurance coverage. This Federal law, which became effective on January 1, 1983, indicated that the employer's plan was to be considered the primary insurance for those persons over sixty-five (65) who were still working and that Medicare would take over payments above the employer's group health plan coverage.

10. In my June 6, 1983 letter to the Department of Insurance (which I have also attached) I indicated my displeasure with Provident to the Department of Insurance since Provident should have paid as primary and I could not even get them to pay the amount which Medicare did not cover. I had tried to point out to the insurance department that since Provident was my primary carrier, they should have paid initially rather than Medicare. I also pointed out that since Provident was withholding payment and allowing Medicare to take over where Medicare was not supposed to, Provident was killing two birds with one stone.

11. Through my complaints with the Insurance Department, I ultimately received satisfaction; however, it still seemed to me that what Provident did was to delay payments until Medicare made the initial payment when Provident should have made the initial payment rather than Medicare.

12. On November 5, 1983, while I was still employed with

The Macke Company, I incurred additional medical expenses due to a recurring knee problem. I went to the doctor for a period of about ten weeks at which time I had already met my deductible with Provident. The doctor I was seeing insisted upon filing a portion of the claims with Medicare. I had incurred expenses for manipulation treatment as well as other expenses, and the doctor was submitting claims for the manipulation treatments to Medicare. My employer would then send the Medicare statement along with the remainder of the bill to Provident. I was extremely frustrated by this because in my previous experience I knew that Provident insisted that claims for all of the expenses be sent to Medicare. It was also frustrating for me since I knew that Provident was supposed to pay as primary but their practice in handling my previous claim was not to do so.

13. After five months, Provident had still not paid any portion of this bill; therefore, I again wrote a letter to the Department of Insurance complaining about Provident. I have attached a photocopy of a letter submitted to the Department of Insurance on May 19, 1984, along with the exhibits I provided to the Department of Insurance.

14. Once again, through my extensive efforts in complaining to the Department of Insurance, Provident ultimately paid the balance of these claims. I am happy that my bills were finally paid, but I am still frustrated and disgruntled by Provident's practice of allowing Medicare to pay as primary when Provident is supposed to pay as primary. Provident collected my premiums and was supposed to pay as primary. Instead, Provident used the Medicare laws to make money and allowed Medicare to pick up the major portion of my bills.

15. Since I was apparently one of the first of Provident's insureds over sixty-five (65) to incur expenses after the January 1, 1983 law went into effect, I felt like I was being treated as a guinea pig, and there were times when my claims were still pending that I was so frustrated I thought I would rather have died at sixty-five than to continue working. The way Provident was handling my claims, I felt like I might be better off if there

had not been a new law since Provident would just have paid as secondary automatically instead of waiting around to see what Medicare was going to do.

Anna Mae Hillenbrand
ANNA MAE HILLENBRAND

State of Indiana
County of Vanderburgh

NOTARY STATEMENT

SWORN TO and SUBSCRIBED before me this 5th day of August _____, 1986.

Mari B. Brown
NOTARY PUBLIC, State of Indiana

My Commission expires:

May 22, 1989

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

August 2, 1990

Mr. Glenn Schimmel
Vice President
Medicare Operations
Blue Cross Blue Shield of Maryland
1946 Greenspring Drive
Timonium, Maryland 21093

Dear Mr. Schimmel:

Senator Pryor, a member of the Permanent Subcommittee on Investigations, was unable to attend the hearing on the Medicare Secondary Payer program on July 11 and 12. He has, however, submitted a question for you to answer for the record. It is as follows:

> Representatives of the General Accounting Office and the Office of the Inspector General have expressed concerns about the potential conflict of interest Medicare contractors may have in complying with the MSP program. What safeguards did your company take to ensure that problems in this area did not, and do not, arise?

We would appreciate your written response to Senator Pryor's question as soon as possible. Thank you for your attention to this matter.

Sincerely,

Sam Nunn
Chairman
Permanent Subcommittee
on Investigations

William V. Roth, Jr.
Ranking Minority Member
Permanent Subcommittee
on Investigations

WVR/sh/sc

United States Senate
COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

August 6, 1990

Glenn Schimmel
Vice President Medicare Operations
Blue Cross Blue Shield of Maryland
1946 Greenspring Drive
Timonium, Maryland 21903

Dear Mr. Schimmel:

On July 11 - 12, 1990, the Permanent Subcommittee on Investigations held hearings on the Medicare Secondary Payer Program. During the course of these hearings, the Subcommittee heard disturbing testimony about the misuse of condition and billing codes by Johns Hopkins Hospital, and perhaps other hospitals as well. I understand that although audits revealing these practices were eventually referred to your fraud and abuse division for action, there has been no further action taken. Johns Hopkins had very poor MSP performance ratings in both its 1988 and 1990 audits. In fact, the recommendation sheets for both audits are virtually identical. I am concerned that the same problems are continuing two years after they were first identified.

I am concerned about MSP compliance at all hospitals, not just Johns Hopkins. The Subcommittee heard allegations that misuse of Medicare codes by hospitals is widespread. Such misuse directly contributes to the failures of the MSP program and a staggering loss of money to the federal government.

I would appreciate you looking into these problems and advising me of your response to these issues.

I do want to thank you for the assistance you and your staff have previously given to the Subcommittee. In particular, the testimony of Jill Jacoby, Susan Howell and Charles Best was most helpful. I look forward to working with you on this important issue.

Sincerely,

William V. Roth, Jr.
Ranking Minority Member

WVR:shc

Blue Cross Blue Shield of Maryland

Medicare

August 30, 1990

The Honorable William V. Roth, Jr.
Ranking Minority Member
U.S. Senate Permanent Subcommittee on Investigations
Room 193
Russell Senate Office Building
Washington, DC 20510-62

Dear Senator Roth:

We are in receipt of your letters dated August 2 and August 6, 1990, posing questions pertinent to the testimony submitted at the July 11 and 12 hearing concerning MSP. What follows is our response to those questions.

Senator Pryor: Representatives of the General Accounting Office and the Office of the Inspector General have expressed concerns about the potential conflict of interest Medicare contractors may have in complying with the MSP program. What safeguards did your company take to ensure that problems in this area did not, and do not, arise?

The Health Care Financing Administration (HCFA), the Blue Cross and Blue Shield Association (BCBSA) and Blue Cross Blue and Shield of Maryland (BCBSMD) recognize the potential conflict of interest inherent in utilizing a private insurer to administer the Medicare Program. That is why the current Medicare Part A Plan Subcontract states in Article 12B that "the Plan shall not use its position as a Medicare contractor for the purpose of furthering its private business interest or for profit or gain nor shall the Plan use any materials or information it obtains from the Secretary or Intermediary or develops in performing its functions under this agreement to promote its private business interests". It is also the reason that the contract requires very strict cost accounting. BCBSMD created the Medicare Division as a unit separate and apart from private operations to protect the integrity of the Medicare Program. The function and activities of the units within the Medicare Division are driven by the tasks and expectations delineated in HCFA's Contractor Performance Evaluation Program (CPEP). This document lists the performance elements we are expected to meet and .. which we are "graded" every year. The Medicare Secondary Payer Program must meet three standards in fiscal year 1990:

1. Administer the program in a manner that achieves maximum savings and cost avoidance to the Medicare Trust Fund.

2. Update the Regional Data Exchange System.

3. Take Action to Prevent Inappropriate Claims to the Medicare Program.

HCFA audits our CPEP performance annually. Consistently poor CPEP performance can lead to the loss of the Medicare contract. It is for this reason that our organizational culture centers on achieving maximum CPEP ranking.

In 1989, our MSP Unit achieved 129% of its Part A savings goal and 121% of its Part B savings goal, an amount totaling almost $34 million. As of July 31, 1990, MSP had achieved 110% of its Part A savings goal and 95% of its Part B savings goal. Such savings would not be possible if we did not treat BCBSMD as we do any other insurer, since they enroll approximateky 49 percent of the market in Marylana in their private business.

Our compliance with CPEP Standards 2 and 3 was audited by HCFA on May 24 and 25, 1990. They awarded MSP maximum points for its "compliance with the basic provisions, and the additional initiatives....undertaken". These additional initiatives include a listing of claims paid by BCBSMD on behalf of Medicare beneficiaries which is voluntarily sent to us on a quarterly basis. We are also supplied with BCBS enrollment and reenrollment information on all Medicare beneficiaries. These nonmandated activitiess yield big savings to the Medicare Program.

In short, our structure, organizational culture, private side conscience and HCFA CPEP audits all ensure that Medicare Trust Fund dollars are appropriately spent.

Senator Roth: The Subcommittee heard allegations that misuse of Medicare codes by hospitals is widespread. Such misuse directly contributes to the failures of the MSP program and a staggering loss of money to the Federal Government. I would appreciate you looking into these problems and advising me of your response to these issues.

A provider's failure to follow MSP regulations can only be verified by an MSP audit. Our MSP Unit conducted four audits during fiscal year 1989 and seven of the ten mandated audits during fiscal year 1990. In all instances, copies of the audit reports were forwarded to the HCFA Regional Office as mandated by the Intermediary Manual.

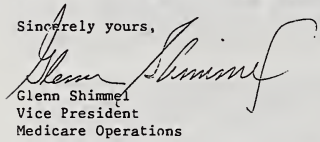
After the April 1990 audit at Johns Hopkins, we elected not to rely on action by the HCFA Regional Office, but to forward our findings to our Fraud and Abuse Unit. The function of that unit is to examine the case, accumulate any available supporting evidence, and then determine if the case should, in fact, be forwarded to the Office of the Inspector General (OIG).

During our Hopkins audit, we identifed 75 cases where, because MSP questions were not asked, Medicare may not have been the true primary payer. Mr. Charles Best phoned the beneficiaries in question and found that in all cases Medicare was, in fact, the primary payer. This information was passed along to our Fraud and Abuse Unit who determined that the case should not be submitted to the OIG. This decision was made because, even though it was clear that Hopkins was not following mandated HCFA procedures, their failure to do so did not result in misspent Medicare monies. The audit findings and analysis by the Fraud and Abuse Unit also suggested that there was no action on the part of Hopkins that represented a fraudulent attempt to obtain Medicare monies that were not otherwise due. Therefore, our decision in this case was to conduct repeated follow-up audits to ensure Hopkins procedural compliance with MSP requirements and report our findings to the HCFA Regional Office.

It should be noted that since the Subcommittee Hearing, we have received numerous calls from providers asking for clarification of the MSP regulations and expressing what we believe is a sincere wish to get their registration and admitting procedures in order.

We appreciate the opportunity to respond to your questions. Should you need any other information, please feel free to contact us.

Sincerely yours,



Glenn Shimmel
Vice President
Medicare Operations

1208A

United States Senate
COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

July 27, 1990

The Honorable Gail Wilensky
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 314G
Washington, D.C. 20201

Dear Ms. Wilensky:

I want to thank you for your testimony before the Permanent Subcommittee on Investigations on July 12, 1990, regarding problems with the Medicare Secondary Payer program. As I said then, I do not envy the problems that you face as the Administrator of the Medicare and Medicaid programs.

I have a few follow up questions that arose during subsequent testimony at the hearing. These questions are as follows:

1. Representatives of Blue Cross Blue Shield of Maryland, the Part A Medicare intermediary for hospitals in Maryland and Washington, D.C., testified that Johns Hopkins Hospital was audited three times between 1988 and 1990 and repeated instances of MSP abuses and lack of compliance were found. Blue Cross stated that all audit reports were forwarded to HCFA for action. What action, if any, was taken by HCFA in response to the repeated, serious problems with MSP compliance at Johns Hopkins? If no action was taken, who made that decision and what was the basis of that decision?

2. Blue Cross representatives asserted that HCFA is well aware of the problems at Johns Hopkins, but has never taken any action against the hospital. What tools does HCFA have available to enforce MSP compliance by recalcitrant hospitals? How often are these tools used?

3. Testimony received at the Subcommittee's hearing suggested that the misuse of Medicare condition and billing codes is widespread among hospitals. Is this true? What is the scope of the problem?

Thank you for your time and attention to this matter.

Sincerely,

William V. Roth, Jr.
Ranking Minority Member

WVR:shc

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT 1 199

The Honorable William V. Roth, Jr.
United States Senate
Washington, D.C 20510

Dear Senator Roth:

I am pleased to respond to your questions, and those you submitted on behalf of Senator Pryor, following the hearing on the Medicare Secondary Payer program. Ensuring that the Medicare program does not pay for services for which private health insurers and other entities are liable is a goal that has been, and will continue to be, at the top of this Agency's agenda.

Similar information has been sent to Senator Sam Nunn. Please let me know if I can provide you with any additional information.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

Enclosure

Question 1.

Representatives of Blue Cross Blue Shield of Maryland, the Part A Medicare intermediary for hospitals in Maryland and Washington, D.C., testified that Johns Hopkins Hospital was audited three times between 1988 and 1990 and repeated instances of MSP abuses and lack of compliance were found. Blue Cross stated that all audit reports were forwarded to HCFA for action. What action, if any, was taken by HCFA in response to the repeated, serious problems with MSP compliance at Johns Hopkins? If no action was taken, who made that decision and what was the basis of that decision?

Answer 1.

Medicare contractors annually conduct a specific MSP review of 10 percent of the hospitals for which they have responsibility. Contractors are instructed to submit a copy of their findings and recommendations, if any, to their HCFA regional office. A follow-up audit is done when necessary. If a hospital refuses to work with the contractor and achieve compliance the case is then referred to HCFA for action. As yet, this has not been the situation with Johns Hopkins.

Blue Cross and Blue Shield of Maryland (BCBSM) performed a routine MSP audit of Johns Hopkins in Fiscal Year (FY) 1988 and a follow-up audit several months later. At the time of the follow-up review, Johns Hopkins informed BCBSM that their long range plan was to complete the installation of an automated inpatient and outpatient admission registration system by 1991 that would improve their billing process. BCBSM performed a subsequent audit in April 1990. While the inpatient billing system was operational, Johns Hopkins had not yet installed the automated system for their outpatient services and as a result the outpatient findings were similar to those found previously.

Blue Cross and Blue Shield of Maryland provided training on MSP requirements to Johns Hopkins outpatient registrars in the fourth quarter of Fiscal Year 1989, and Hopkins plans additional training seminars in the future. BCBSM is working with Hopkins to make sure these take place.

Johns Hopkins has now installed their outpatient billing system, and BCBSM began another MSP review in August 1990. BCBSM will complete their review in September, and in October will report their findings and recommendations to the HCFA Regional Office.

Question 2.

Blue Cross representatives asserted that HCFA is well aware of the problems at Johns Hopkins, but has never taken any action against the hospital. What tools does HCFA have available to enforce MSP compliance by recalcitrant hospitals? How often are these tools used?

Answer 2.

The review process, as described in the answer to question number one, illustrates the usual procedures that HCFA employs to ensure compliance with the MSP rules.

One approach HCFA can use to further encourage compliance with MSP procedures is to deny payment on claims that are submitted with incomplete insurance information. HCFA has the option of not assuming responsibility for primary payment until the provider clarifies the beneficiary's insurance status. HCFA does not send all claims back to a provider for clarified MSP information unless it appears that the provider is not making progress in resolving its billing problems. Such actions complicate claims processing for beneficiaries, adversely affect a providers cash flow, and significantly increase administrative costs of processing claims from that provider.

In the event that a provider submits a claim which indicates no insurance coverage where coverage in fact exists, HCFA can hold the provider responsible to reimburse HCFA for the Medicare payment and can require the provider to recover payment from the insurance company.

The final mechanism that HCFA has available to enforce MSP compliance is to terminate the hospital's provider agreement with Medicare. This authority was established in regulations effective in November 1989. To date, this has not been necessary. Johns Hopkins is actively working to update their outpatient department billing system and is working with the contractor to achieve compliance.

Question 3.

Testimony received at the Subcommittee's hearing suggested that the misuse of Medicare condition and billing codes is widespread among hospitals. Is this true? What is the scope of the problem?

Answer 3.

We believe that, in general, most hospitals do a reasonable job in identifying and billing other payers. Fiscal intermediary audits have found no widespread misuse of condition and billing codes on Medicare inpatient claims. A recent nationwide audit of 92 hospitals conducted by HCFA and several intermediaries, found that hospitals and contractors jointly have been successful in identifying 95 percent of the existing MSP situations in the inpatient setting.

Questions submitted on behalf of Senator Pryor:

Question 1:

How does HCFA intend to recoup the enormous losses Medicare has sustained over the last several years due to problems with implementation of the MSP program? What has HCFA done, and what does HCFA plan to do, to ensure prevention of future losses?

Answer 1:

HCFA has devoted significant effort and resources to strengthening the enforcement of secondary payer provisions. We will continue activities that are currently underway to recoup MSP losses. The Department of Justice has filed suit against three insurance companies for violations of the secondary payer provisions.

We have updated our MSP regulations by publishing a comprehensive rule incorporating all MSP requirements, except those for disability. A proposed rule addressing the disabled was issued on March 8 and is now being prepared for publication in final form. We plan to publish a Notice in the Federal Register announcing changes in the MSP provisions contained in P.L. 101-239 (OBRA 89). Subsequently, we will issue proposed rules to implement the OBRA 89 changes.

In our effort to ensure prevention of future losses, we have pursued an extensive educational campaign for State insurance commissioners, insurers, employer groups and physicians, as well as developed a series of radio and TV public service announcements and informational presentations to beneficiaries, providers, employers, insurers and third party administrators.

Finally, and most importantly, OBRA 89 legislation requires a complex data match among the IRS, SSA and HCFA. This will greatly strengthen our ability to identify beneficiaries who have health coverage through their working spouse's employer group health plan. These beneficiaries represent the

largest category of undiscovered secondary payer savings, and the data match will help us avoid costs of future claims by supplying information. We are proceeding with a series of activities to implement the data match, and expect to begin processing recovery actions by early 1991.

Question 2:

The Special Committee on Aging has received numerous reports of instances where the implementation of the MSP program has had harsh and unjust consequences on older Americans. For example, the following concerns have been brought to the attention of the Committee:

- The HCFA unlimited recovery rule results in Medicare recovering its payments from moneys allocable to other beneficiary costs;
- Current MSP recovery procedures do not provide for due process rights for beneficiaries; and
- Overly aggressive efforts to identify MSP beneficiaries have resulted in numbers of Medicare beneficiaries being denied Medicare payments to which they are entitled as a result of being erroneously labelled on the insurance company computers as having other health insurance.

Are these practices widespread? Are any legislative remedies necessary? What is HCFA doing to ensure needed protections for beneficiaries?

Answer 2:

The Medicare Secondary payer program and the efforts to recover funds are complex. We try to take each beneficiary's situation into account in the process of recovering funds that must be repaid to the government. If beneficiaries believe that they have been erroneously labeled as having primary health coverage, the contractors should be able to work with the beneficiaries to clarify these situations. Beneficiaries do have due process rights with respect to questioning the MSP recovery process.

Whenever a contractor seeks recovery of Medicare payments from a beneficiary, the beneficiary is informed of his right to request a waiver under the principles of equity and good conscience or economic hardship. Waiver cases are reviewed by HCFA on an individual basis, and HCFA considers such things as the physical condition of the beneficiary and the extent of beneficiary out-of-pocket medical expenses for non-

Medicare covered services. Within the last year, clarification was sent to contractors on the process for informing beneficiaries of their right to request a waiver in liability cases.

HCFA's policy of basing its recovery on a total liability settlement is based on the statutory language which prohibits Medicare from paying where a liability insurance payment is made or can be made with respect to the services. Since the entire liability payment is by its very nature with respect to medical items and services furnished to treat the injured party, Medicare has the right to recover its payments from the entire settlement regardless of how payments may be designated in the settlement. Otherwise, the parties could manipulate settlements in such a way as to increase amounts designated as payment for pain and suffering with a corresponding decrease in payments for medical expenses. To recognize such settlements would defeat the purpose of the MSP provisions because it would minimize the amount of reimbursement due the Medicare program.

Question 3:

What efforts has HCFA made to ensure that the conflict of interest that may exist on the part of the Medicare contractors is not detrimental to the implementation of the MSP program? Have the contractors been receptive to your efforts, and, if not, what is HCFA doing in response?

Answer 3:

The MSP provisions create a potential for conflict of interest, as some carriers and intermediaries are also the primary insurers. Recognizing this inherent conflict, HCFA has taken steps to ensure that its contractors process claims in accordance with the MSP provisions.

Contractor performance of MSP functions is monitored through the contractor performance evaluation program (CPEP). Under this formal evaluation program, the contractors must meet certain performance standards.

Contractors are assigned goals to be achieved for participation in the MSP program. These goals are dollar amounts that represent the savings to the Medicare Trust Funds attainable by the contractor due to effective implementation of the secondary payer provisions. These are monies that are either recovered from inappropriate payments or costs that are avoided by assuring correct payer status. Contractor savings are reviewed to determine validity and the presence of documented audit trails.

The CPEP also determines whether proper procedures are being used to identify MSP situations and if bills are being sent to the appropriate primary payers. Corrective actions are suggested where necessary to improve deficiencies.

HCFA previously attempted to require contractors to match their Medicare records with records from the private side of their businesses as a means of detecting MSP cases. The contractors, however, were opposed to this requirement, claiming that it would put them at a competitive disadvantage with other insurers who are not Medicare contractors. Furthermore, OBRA 89 barred HCFA from requiring such data matches. We are now considering other options for obtaining information such as requiring employers to report certain health insurance information.

Senate Permanent Subcommittee on Investigations

EXHIBIT # 22

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

August 2, 1990

Ms. Constance C. Clark
Director of Patient Accounts
Johns Hopkins Hospital
Administration Building 3-309
600 North Wolfe Street
Baltimore, Maryland 21205

Dear Ms. Clark:

Senator Pryor, a member of the Permanent Subcommittee on Investigations, was unable to attend the hearing on the Medicare Secondary Payer Program on July 11 and 12, He has, however, submitted some questions for you to answer for the record, they are as follows:

You recommend that the information regarding MSP should be collected by the Social Security Administration and/or the Medicare contractor. However, given that employment status and private health insurance coverage can change, and change very quickly, particularly among older people, how can SSA and the contractors ensure that their information is up-to-date? Is not the hospital and/or other providers the most likely place to gather the most current information?

You stated in your testimony that you do not believe that MSP is a significant problem, given that only 14 out of 642 Medicare patients were found to be employed in a recent audit at your hospital. Yet Blue Cross/Blue Shield of Maryland has paid out over $8 million in Medicare claims in which Medicare should have been the secondary payer. How do you account for a figure of that magnitude if MSP is not a significant problem?

We would appreciate your written response to Senator Pryor's questions as soon as possible. Thank you for your attention to this matter.

Sincerely,

Sam Nunn
Chairman
Permanent Subcommittee
on Investigations

William V. Roth, Jr.
Ranking Minority Member
Permanent Subcommittee
on Investigations

WVR/sh/sc

The
Johns Hopkins
Hospital

600 North Wolfe Street/Administration 3-309
Baltimore, MD 21205
(301) 955-5151

Constance L. Clark, C.P.A.M.
Director, Patient Accounting

September 15, 1990

U. S. Senate
Committee on Government Affairs
William V. Roth, Jr.
Washington, D.C. 20510-6250

Dear Senator Roth,

This is my response to Senator Pryor's questions regarding my testimony on the Medicare Secondary Payor Program.

First Issue: Clarification on my suggestion that Social Security and/or Medicare be responsible for tracking Medicare patients and their primary payor status.

Response: My reason for this recommendation was to point out that the hospital can only collect information from the Medicare patients on the day of their visit. Patients may be confused or may choose to withhold information. Additionally, patients object to providing information at every visit. Perhaps a periodic check, e.g. quarterly would address this patient concern.

Second Issue: Clarification on my statement that I do not believe that MSP is a significant problem.

Response: In my written testimony I proposed that a study be conducted to identify the true potential savings of the MSP Program. Perhaps the total savings could be compared to both the total program dollars and total cost in order to derive an estimated net savings.

Thank you for giving me this opportunity to respond to your questions.

JOHNS HOPKINS HEALTH SYSTEM

Sincerely,

Constance L. Clark
Director, Patient Accounting
The Johns Hopkins Hospital

CLC/tjc

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